MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Director, Program Policy Division
Bureau of Policy and Federal Affairs
Medical Services Administration

Project Number:	0338-PRAC	**Comments Due:**	7/21/03	**Proposed Effective Date:**	10/01/2003

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Policy Subject: Chapter III (Coverage and Limitations for Practitioners) revisions and clarifications.

Affected Programs: Medicaid, Children's Special Health Care Services, State Medical Program, Maternity Outpatient Medical Services (MOMS) Program

Distribution: Physicians, Certified Nurse Midwives, Nurse Practitioners, Certified Registered Nurse Anesthetists, Medical Clinics, Optometrists, Oral Surgeons, Physical Therapists, Podiatrists, Community Mental Health Services Programs, Medicaid Health Plans, Private Duty Nurses

Policy Summary: This bulletin transmits a revised Chapter III (Coverage and Limitations for Practitioners). This chapter incorporates bulletins issued since the last chapter III revision. Policy changes and clarifications are included. This chapter becomes effective for dates of service on or after 10/01/2003. Please note the following changes:

- Alignment with CPT and CMS coverage and coding guidelines in several areas.
- Assistant at surgery coverage for physician assistants and nurse practitioners.
- Further alignment with the Medicare Correct Coding Initiative (CCI).

It is anticipated that the formatting and writing style of this document will be modified to comply with the new Medicaid manual template prior to final release.

Proposed Policy Draft

Michigan Department of Community Health
Medical Services Administration

Distribution: Physicians
Medical Clinics
Certified Nurse Midwives
Nurse Practitioners
Certified Registered Nurse Anesthetists
Community Mental Health Services Programs
Optometrists
Oral Surgeons
Physical Therapists
Podiatrists
Private Duty Nurses

Issued: August 1, 2003 (proposed)

Subject: Chapter III (Coverage and Limitations for Practitioners)

Effective: October 1, 2003

Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Program, Maternity Outpatient Medical Services (MOMS) Program

This bulletin transmits the revised Chapter III (Coverage and Limitations for Practitioners). As a part of the chapter revision process, previously issued policy bulletins have been incorporated. Rewording and clarification of existing policy and policy changes have been incorporated which reflect issues raised and clarifications requested by the provider community and within the Department of Community Health (DCH).

The attached Chapter III is effective for dates of service on or after 10/01/2003. The revisions to this chapter include HIPAA mandates and further refine the uniform billing project goal of consistency between Medicaid and other payers.

In reviewing this chapter, please note the following:

- Improved alignment with CPT and CMS coverage and coding guidelines in several areas.
- Assistant at surgery coverage for physician assistants and nurse practitioners.
- Further alignment with the Medicare Correct Coding Initiative (CCI).
- Reorganization of information into major heading areas.

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GENERAL INFORMATION

Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered. The services addressed in this chapter include services which require explanation or clarification, have special coverage requirements, require prior authorization, or must be ordered by a physician.

Information is included to assist the practitioner in determining how specific services are covered by the Program. This information should be used in conjunction with the Billing and Reimbursement for Health Care Professional Chapter of this manual, as well as the practitioner and related procedure databases located on the Department's website at www.michigan.gov/mdch.

ADMINISTRATIVE SERVICES

Services of physicians, medical staff or other licensed or certified health professionals functioning in an administrative or teaching capacity for a hospital or nursing facility (including physician-owners or other staff paid by the physician) are not covered separately as physician services.

Pathology services or interpretive studies done for hospital or nursing facility quality improvement purposes or other reasons which do not directly assist with the specific care of a specific beneficiary are considered to be administrative services and are not separately covered as physician services. These services are included in the facility's allowable costs and are paid to the facility.

BILLING FOR DELEGATED SERVICES

Physician services provided by the physician's employees or employees of the same legal entity that employs the physician are billed to the Program under the delegating physician's ID number as if he/she performed the services personally. Services performed by a physician's assistant (PA) may be billed to the Program only by the physician who has complied with all requirements for utilizing PAs per Public Act 368 of 1978, as amended, and any related rules promulgated by the State of Michigan or its Departments.

COMPONENT SERVICES

Many physician services are covered as global services. A global service includes all resources necessary to perform the procedure (e.g., office overhead, equipment, supplies, and staff) and the services provided by the physician (e.g., interpretation of results and preparation of a report of findings).

Some services are divided into a professional component and a technical component for coverage purposes. The professional component includes the services provided by the physician while the technical component includes equipment, supplies, and technical staff.

Coverage for the professional component or the technical component generally depends on where the service is provided and who provides that portion of the service. Services for which the professional component is covered for the physician are identified in the practitioner databases on the DCH website by the modifier that designates a professional component. If this modifier is not present in the databases for a specific procedure code, the professional component is not covered for the physician.

Global services are covered for the physician in non-hospital settings and the professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in a hospital setting and is payable to the hospital. The global

service and it's professional component service cannot both be covered for the same service since the professional component is included in the global service.

CO-PAYMENTS

The applicable co-payments that a beneficiary is required to pay for certain services (e.g., podiatry services to beneficiaries age 21 and over) are identified in the appropriate section of this manual. The physician should note that a co-payment is not required for:

- beneficiaries under age 21,
- beneficiaries in a nursing facility,
- beneficiaries having Medicare when the service is covered by Medicare, and
- pregnancy-related drugs. (The pharmacy has a list of these drugs.)

If the beneficiary is unable to pay a required co-payment on the date of service, the provider CANNOT refuse to render the service. The provider may bill the beneficiary for the co-payment amount, and he/she is responsible for paying it.

If the beneficiary fails to pay a co-payment, the provider could, in the future, refuse to serve the beneficiary.

FACILITY AND NON-FACILITY REIMBURSEMENT

Medicaid reduces payment for specified procedures provided in a facility setting. This policy is consistent with CMS's facility and non-facility reimbursement determination. When a provider performs services in a facility setting, costs for certain procedures are reduced as the practitioner does not incur certain overhead expenses (such as clinical staff, supplies, equipment) necessary to provide the service. When a service is performed in a non-facility setting, the payment rate will be based on the non-facility relative value units (RVUs). When the service is provided in a facility setting, the payment rate will be based on the facility RVUs. The payment difference takes into account the higher expenses for the provider in the non-facility setting. For the purpose of this payment policy, a facility includes the following:

- Hospital inpatient and outpatient facilities
- Psychiatric facilities
- Skilled nursing facilities
- Ambulatory surgery centers
- Rehabilitation facilities

HOSPITAL BASED PROVIDER

The Program covers services by hospital-based providers (HBPs). A hospital-based provider is employed by the hospital. Each HBP is assigned his/her own seven-digit Medicaid identification number. For purposes of the Program, a HBP includes an M.D., D.O., Certified Registered Nurse Anesthetist (CRNA), podiatrist, optometrist, or nurse-midwife.

The HBP should refer to the appropriate manual for policies, procedures, and coverage information (e.g., a physician would use this manual, a dentist would refer to the Dental Manual).

The Program follows Medicare guidelines for the coverage of HBP services.

MEDICARE RELATED SERVICES

The Program will reimburse the physician for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. Refer to the billing and reimbursement and coordination of benefits chapters of this manual for instructions on completing the Medicaid claim after Medicare has approved the service.

PHYSICIAN DELEGATION AND SUPERVISION

All physician services covered by the Program must be performed by the physician personally, the physician's employee, or an employee of the same legal entity that employs the physician, under the physician's delegation and supervision. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., physician's assistant, nurse practitioner, certified nurse midwife) as authorized by Public Act 368 of 1978, as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises. The delegating/supervising physician must be continuously available through direct communication such as telephone, radio, or telecommunication when not on the premises.

In the physician's absence, medical services must be provided by licensed persons under the physician's delegation and supervision at the medical care site where the physician regularly sees beneficiaries. Records must demonstrate that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to and does not replace the physician's personal services.

Care and treatment of Medicaid beneficiaries may only be delegated to unlicensed/certified persons when the physician is physically present and providing direct supervision.

PHYSICIAN RESPONSIBILITY

Determination of medical necessity and appropriateness of services is the responsibility of the physician within the scope of currently accepted medical practice and the limitations of the Program. The physician will be held responsible if he/she orders excessive or unnecessary services (e.g., diagnostic tests, prescriptions) regardless of who actually renders or who receives payment for the service. The physician may be subject to any corrective action related to these services, including recovery of funds.

Services generally must be ordered by a physician to be covered by the Program. Some services provided by other providers such as medical supplies, lab services, and prescriptions may require the physician to provide written documentation to support the need for the service. If the practitioner is not certain whether a service is a covered benefit, he/she can refer to the practitioner databases posted on the DCH website or contact the Program for coverage information.

PRIOR AUTHORIZATION (PA)

The Program requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of prior authorization is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- procedures identified as requiring PA on the procedure code databases on the DCH website

- those that are normally non-covered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery)
- referrals for elective services by out-of-state non-enrolled providers

To obtain PA:

The provider must submit a letter to:

Prior Authorization and Review Section
Medical Services Administration
P. O. Box 30170
Lansing, Michigan 48909
Or
Fax it to: (517) 335-0075

The letter and materials submitted requesting prior authorization must include:

- patient name and Medicaid ID number
- provider's name, address, Medicaid provider ID number
- contact person and phone number
- a complete description, including CPT/HCPCS procedure codes as appropriate, of the procedure(s) that will be performed
- the patient's past medical history, including other treatments/procedures that have been tried and the outcome, diagnostic test results/reports, expectations and prognosis for the proposed procedure, and any other information to support the medical need for the service.

The provider will receive a written response from the Program. If the authorization is granted, the provider will receive a nine-digit authorization number to report on the claim. The physician obtaining PA must make the PA number available to other providers such as other practitioners or the hospital for billing purposes.

If the beneficiary has Medicare and Medicare covers the service, the provider does not have to obtain PA from Medicaid. If Medicare denies a service as not medically necessary, Medicaid will not cover the service even if PA has been obtained. If Medicare identifies a service as an excluded benefit under Medicare and Medicaid requires PA, the provider must pursue PA from Medicaid and a coverage determination will be made. If the beneficiary has commercial insurance that covers the service and the provider reports the coverage correctly on the claim, the provider does not have to obtain PA from Medicaid. If a primary insurer will cover a service but requires PA and the provider does not follow the primary insurance PA process, Medicaid will not make payment for the service either.

Special Authorizations

Special authorization requirements must be met for selected surgeries performed in the inpatient setting, all elective inpatient admissions, all readmissions within 15 days, and all transfers to an inpatient hospital/unit. Physicians should refer to the Inpatient Care and Surgery sections of this chapter for specific information.

Some beneficiaries may need authorization of services because they are enrolled in special programs such as the Beneficiary Monitoring Project. Refer to Chapter II, BENEFICIARY ELIGIBILITY, Special Programs, for information.

SERVICES IN A TEACHING SETTING

The administrative costs associated with teaching physician services, as well as payment for direct patient care services provided by a resident (including interns or fellows) in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by CMS for Medicare. Services covered by Medicaid under these guidelines must be identified with the appropriate modifier.

Teaching institutions and teaching physicians within those institutions must abide by the CMS teaching physician guidelines which explain when services provided in teaching settings can be covered by Medicaid or must be included as allowable medical education costs on the hospital's cost report.

Briefly, the guidelines require the presence of the teaching physician during the key portion of the performance of the service in which a resident is involved for which payment will be sought by the teaching physician (or the hospital on the behalf of the physician). The medical record must fully support the physician's presence and participation in the service provided. There are exceptions and other considerations that may apply, and the full text of the guidelines must be consulted to ensure compliance. Any services that meet the teaching physician criteria must be reported with the appropriate modifier.

CMS provides an exception to the physician presence requirement for some low and mid-level E/M services furnished in certain primary care centers when specified conditions are met. For Medicaid, the preventive medicine E/M visits are also included under the "presence" exception for services provided in the primary care centers by residents. The appropriate modifier must be reported when E/M services are provided by residents under the "presence" exception. The E/M services that can be reported with this modifier include office or other outpatient visits requiring straightforward or low complexity medical decision making and comprehensive preventive medicine visits. For higher-level services and all invasive procedures, the teaching physician must be present.

Services of residents or physicians/medical staff functioning in an administrative, teaching or learning capacity in the hospital or long-term-care facility are that are covered as individual physician services, are subject to post payment review and recovery of funds unless the provider can present proof that the services were not included in the allowable facility costs.

SERVICES TO NEWBORNS

Physician services provided to newborns are covered under the newborn's Medicaid ID number. The mother's Medicaid ID number cannot be used. **Exception:** If the newborn's care and circumcision are performed by the delivering physician during the mother's inpatient stay, these services can be covered under the mother's Medicaid ID number **if they are billed on the same claim as the services to the mother.**

UNIFORM REPORTING OF SERVICES

The Program uses the Medicare Correct Coding Initiative (CCI) policy as a guideline for determining when services are covered in addition to, or are included in, other services provided on the same day. The CPT/HCPCS procedure code descriptions are based upon current medical practice. In order to submit a CPT/HCPCS code to Medicaid, the provider must have performed all of the services included in the code description. Providers must not submit codes describing components of a comprehensive code in addition to the comprehensive code (unbundling). Components are individual services necessary to accomplish the more comprehensive procedure/service.

Mutually exclusive code pairs represent services or procedures that would not or could not be reasonably performed on one beneficiary during the same session by the same provider based on standard medical practice. Codes representing these services cannot be submitted together.

Certain codes are identified as "separate procedures." These are commonly carried out as an integral part of another service and are not covered separately. However, at times these services may be provided independently, or unrelated or distinct from other procedures on the same day. It may be appropriate to report a separate procedure with the distinct procedural service modifier in these instances. The addition of this modifier to a procedure code indicates that the procedure represents a "distinct procedure or service from others billed on the same date of service." This may represent a different session, different surgery, different anatomical site, different agent, different lesion, or a different injury or area of injury (in extensive injuries).

When CPT/HCPCS descriptions designate several procedures of increasing complexity, only the code describing the most extensive procedure actually performed is covered. Certain CPT/HCPCS descriptions designate procedures performed "with" or "without" other services. Submit only the code(s) describing the service(s) actually performed. When the descriptions identify procedures requiring a designation for male or female, submit the appropriate code for the gender of the patient.

ANESTHESIA SERVICES

The Program covers anesthesia services provided by qualified practitioners in conjunction with covered surgeries and other procedures. Refer to the anesthesia database on the DCH website for specific covered anesthesia services. The Program does not cover any anesthesia service related to the treatment of infertility.

MEDICALLY DIRECTED ANESTHESIA SERVICES

The Program covers anesthesia services provided by physicians and certified registered nurse anesthetists (CRNAs) for medically directed anesthesia services consistent with anesthesia team practice. (See the CRNA portion of the this manual for additional CRNA enrollment and coverage information). The Program recognizes medical direction of general anesthesia, regional anesthesia, and reasonable and medically necessary Monitored Anesthesia Care (MAC). The physician cannot medically direct more than four concurrent anesthesia cases at one time and cannot perform any other services during the same period of time except as outlined below. In all cases in which medical direction is furnished, the physician must be physically present in the operating suite.

All of the following conditions must be met for medically directed anesthesia services to be reimbursed to the physician. For each patient, the physician must:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;
- Ensure that any procedures in the anesthesia plan that he or she does not personally perform are performed by a qualified individual;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

The medical direction service furnished by a physician is not covered if the physician directs a non-qualified individual. A qualified individual is a CRNA, a student anesthetist, an anesthesiologist's assistant, or an intern or resident.

The physician must document in the beneficiary's medical record that he or she performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and present during the most demanding procedures, including induction and emergence, where indicated. Total anesthesia time must be documented in the medical record.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another physician member fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate the services were furnished by physicians and identify the physician(s) who rendered them.

A physician who is directing the concurrent administration of anesthesia to four or fewer surgical patients should not be involved in furnishing additional services to other patients. If the physician is addressing an emergency of short duration in the immediate area, or administering an epidural or caudal anesthetic to ease labor pain, or providing periodic rather than continuous monitoring of an obstetrical patient, it does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. A physician may also receive patients entering the operating suite for subsequent surgeries, may check on or discharge patients from the recovery room, and may handle scheduling matters while directing concurrent anesthesia procedures without affecting coverage for medical direction.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is not available to respond to the immediate needs of the surgical patients, the physician's services are considered supervisory and are not covered as medical direction.

Medically directed anesthesia services are covered when provided by an anesthesiologist who is monitoring more than four concurrent anesthesia procedures, or who is performing other services while directing the concurrent procedures, in select instances. The physician must personally provide the pre-anesthesia exam and evaluation, prescribe the anesthesia plan, and be in the operating suite during the entire procedure. A flat rate payment is made to cover the physician's involvement in pre-surgical anesthesia services. Medically supervised CRNA services are covered and are reported with the appropriate modifier.

Medicaid covers anesthesia services consistent with Medicare guidelines when provided under an "attending physician" relationship in a teaching hospital and/or in accordance with the coverage guidelines established by the Medicare policies for teaching physicians.

NON-MEDICALLY DIRECTED ANESTHESIA SERVICES BY THE CRNA

Anesthesia services provided by a CRNA under the supervision of the surgeon or another physician who is immediately available if needed are covered as non-medically directed anesthesia services. The Program will reimburse the CRNA for these services if all of the following conditions are met:

- the facility in which the services are rendered ensures that the anesthesia services are provided in a well-organized manner under the supervision of a physician (MD or DO),
- the facility is responsible for all anesthesia administered in the facility,
- a pre-anesthetic exam and evaluation is provided within 48 hours prior to the surgery by a physician (MD or DO) or a CRNA under the supervision of a physician,
- an intra-operative anesthesia record identifies the CRNA providing the anesthesia service and the supervising physician,
- for inpatients, a post-anesthesia follow-up report is written within 48 hours after surgery by the person administering the anesthesia, and
- for outpatients, a post-anesthesia evaluation for proper anesthesia recovery is performed in accordance with the policies and procedures approved by the medical staff.

There is no separate coverage for the physician for any portion of the non-medically directed anesthesia services. The physician's supervisory service is covered as part of the facility charge

where the surgery is performed. The pre-anesthetic exam and post-anesthesia evaluation is included in the anesthesia coverage for the non-medically directed CRNA care and is not separately covered. Payment for the non-medically directed anesthesia service provided by the CRNA is made to the CRNA or the legal entity employing the CRNA.

There is no separate coverage for anesthesia services performed by the physician who is also performing the medical or surgical service requiring the anesthesia. Any anesthesia service provided personally by the surgeon is included in the coverage for the surgical procedure itself.

MONITORED ANESTHESIA CARE (MAC)

MAC is covered on the same basis as other anesthesia services as long as it is reasonable and medically necessary. MAC involves the intra-operative monitoring by a physician, or by a qualified anesthesia provider under the medical direction of a physician, or by a CRNA under the supervision of a physician of the patient's vital physiological signs, in anticipation of the need for administration of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., Atropine, Demerol, Valium) and provision of indicated post-operative anesthesia care.

MEDICAL AND SURGICAL SERVICES FURNISHED IN ADDITION TO ANESTHESIA SERVICES

Separate coverage is available for certain medical or surgical services furnished by a physician while furnishing anesthesia services to the beneficiary. The services may be furnished in conjunction with the anesthesia procedure to the patient or as single services, e.g., the day of or the day before the anesthesia service. These services include insertion of a Swan Ganz catheter, the insertion of central venous pressure lines, emergency intubation, and critical care. Separate coverage is not available for medical or surgical services, such as the pre-anesthetic examination of the patient, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service will be made.

The insertion of the epidural catheter is covered in addition to the anesthesia services for labor and delivery by the physician or CRNA under the physician's supervision. The epidural insertion is covered as a surgical service. Anesthesia services provided by a physician or CRNA during delivery are covered under the same policies that apply to general or monitored anesthesia care.

POST-OPERATIVE PAIN MANAGEMENT

Post-operative pain management is the responsibility of the surgeon (except in special circumstances) and is covered as part of the global service provided by the surgeon.

Placement of a continuous epidural to manage post-operative pain is separately covered under the appropriate CPT/HCPCS code for a continuous epidural when the physician (or CRNA under a physician's supervision) performed the service for post-operative pain management and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent post-operative days is covered under the appropriate procedure code.

ANESTHESIA TIME

Anesthesia time means the time during which the anesthesia provider (physician providing anesthesia or the CRNA) is furnishing continuous anesthesia care to the beneficiary. It starts when the anesthesia provider begins to prepare the patient for induction of anesthesia and ends when the beneficiary may be safely placed under post-operative supervision and the anesthesia provider is no longer in personal attendance. In counting anesthesia time when an interruption in

the anesthesia service occurs, only the actual anesthesia time is counted. The anesthesia start and stop times must be documented in the medical record.

ELECTRO-CONVULSIVE THERAPY

Anesthesia services related to electro-convulsive therapy are covered by the beneficiary's Community Mental Health Service Program (CMHSP) or Medicaid Health Plan (MHP). The attending physician must obtain authorization from the CMHSP or the MHP. Payment is made by the CMHSP or MHP that authorized the service.

PRIOR AUTHORIZATION FOR ANESTHESIA SERVICES

If a surgical procedure requires prior authorization, the operating surgeon is responsible for obtaining the authorization to perform the service. The anesthesia provider is not responsible for providing proof that the surgical procedure was authorized.

HYSTERECTOMIES AND STERILIZATION PROCEDURES

By federal statute, all services, including anesthesia services related to hysterectomies or sterilization procedures must be supported by an informed consent which meets the Program's consent requirements before the service can be covered. It is the responsibility of the operating surgeon to obtain this consent.

USING MODIFIERS

Anesthesia services must be coded using the appropriate CPT/HCPCS anesthesia codes with the appropriate modifiers. Anesthesia services for multiple surgeries are reported under the anesthesia procedure code with the highest base unit value with the total anesthesia time, in minutes, including all surgical procedures.

Refer to the MDCH website for specific modifiers required for use with anesthesia services.

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes are covered in addition to the primary anesthesia code. Coverage for anesthesia add-on codes is based on the anesthesia base units (ABUs) established by CMS for the specific anesthesia add-on code. **Exception:** Obstetrical anesthesia add-on codes are covered based on the ABUs assigned by CMS plus the anesthesia time units associated with the anesthesia add-on code.

LABOR AND DELIVERY

Coverage of anesthesia services associated with labor and delivery is based on the type of anesthesia provided. If anesthesia is provided by placement of an epidural catheter, it is covered under the appropriate anesthesia code depending on the type of delivery. The coverage for this service includes any needle placement, drug injection, and any replacement of the epidural catheter during labor. If endotracheal or general anesthesia is provided for the delivery, it is covered under the appropriate anesthesia code. If an epidural catheter is inserted for labor and delivery but it is later necessary to provide endotracheal anesthesia for the delivery, the surgical code for the epidural insertion is covered in addition to the anesthesia service code for the delivery. The medical record must fully document the circumstances requiring both types of anesthesia.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) to eligible Medicaid beneficiaries under 21 years of age; however, beneficiary participation is voluntary. The intent is to find and treat problems early so they do not become more serious and costly. Accordingly, EPSDT visits and any needed follow-up services are covered.

The main parts of the EPSDT program that providers are responsible for are:

- well child visits, including immunizations
- referrals for:
  - other preventive health care
  - medically necessary follow-up services to treat detected conditions
- transportation and reporting

WELL CHILD VISITS

The Michigan Department of Community Health (MDCH) supports the concept of a medical home for each Medicaid beneficiary. A medical home is a primary care provider who assumes responsibility for assuring the overall care of an individual, and for the maintenance of an individual's medical record. When a physician or other primary care provider accepts a child in a primary care relationship, the provider takes responsibility for arranging or providing well child/EPSDT visits and updating the child's medical record at each visit.

Well child visits are the health checkups, newborn, well baby, and well child exams represented by appropriate Current Procedural Terminology (CPT) preventive medicine services procedure codes if they are used in conjunction with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes V20.0 - V20.2, V70.0, and/or V70.3 - V70.9

The periodicity schedule indicates all components and age-specific indicators for performing the various components.

OUTREACH

The MDCH provides outreach to beneficiaries through various means, including informational publications and other beneficiary contacts.

When the MIHealth Card is issued, it is mailed with the MDCH Pub 492 (containing English, Spanish, and Arabic text). Pub 492 is entitled "A Hug Shows You Care" and it explains the benefits of a well child visit, indicates the recommended periodicity schedule, describes procedures included in the free health checkup, and presents information about transportation.

Soon after the MIHealth Card is issued, the case is included in a monthly outreach list and the grantee receives a letter that stresses the importance of well child visits and provides transportation information.

Fee for Service

For beneficiaries under two years of age, the letter is sent every six months. The grantee is encouraged to schedule the visits recommended during those six months with the child's provider.

For beneficiaries two years of age and older, if a claim for a well child visit has not processed through our system by the time the child is half way to his/her next "due" date according to the periodicity schedule, the grantee receives the letter again.

The letters generate a list of fee-for-service beneficiaries that goes to the local health department. Local health departments may assist in informing beneficiaries of the EPSDT program, scheduling appointments, and explaining transportation options.

Medicaid Health Plan (MHP)/Children's Special Health Care Services Special Health Plan (SHP)

Each MHP/SHP is able to download an electronic monthly outreach list of enrollees due or overdue. The health plan must either notify the grantee directly or may have the local health department assist in notification, scheduling appointments, and explaining transportation options.

Once each year, "A Hug shows You Care" is mailed to the grantee of each Medicaid case.

TRANSPORTATION

Transportation is available (free of charge to the beneficiary) for travel to and from well child visits, if requested by the family.

- For those enrolled in an MHP or SHP, the family needs to make arrangements directly through that plan or with the assistance of the local health department.
- Beneficiaries not enrolled in an MHP or SHP need to contact their local Family Independence Agency directly or with the assistance of the local health department to make transportation arrangements for the EPSDT visit. It may take some time to make these arrangements, so the Family Independence Agency needs to be contacted as soon as the date and time of the appointment are known.

PERIODICITY SCHEDULE AND COMPONENTS

The table titled "EPSDT COMPONENTS BY AGE OF BENEFICIARY" indicates the periodicity schedule and components for well child visits.

Head Start agencies are directed by federal regulation to meet state EPSDT standards for health screening. The MDCH urges providers to cooperate with these agencies. Results of well child visits may be shared if requested, since Head Start agencies are bound by confidentiality standards.

Providers must complete all testing components at the specific ages indicated on the periodicity schedule. Well child visits may be performed more frequently than the periodicity schedule indicates if required by court order, foster care standards, or if considered medically necessary. The child's medical record must reflect documentation of the circumstances.

The following sections are meant to provide further guidance to providers when following the "EPSDT Components By Age Of Beneficiary" table.

HISTORY

Immunization Review

A review shall be performed at each visit, with immunizations administered according to current recommendations and standards of practice recognized by the AAP and the US Public Health Service Advisory Committee Immunization Practices (ACIP). Providers are reminded that all immunizations should be reported to the Michigan Childhood Immunization Register (MCIR).

Initial/Interval History

An initial history must be obtained for each new patient at the first well child visit, with an update (interval history) at each subsequent well child visit.

Sample history forms from other states are located at www.michigan.gov/mdch; click on Providers (left side of the screen), Information for Medicaid Providers (left side of the screen), and Medicaid Provider Forms and Other Resources (center of the screen).

MEASUREMENTS

Blood Pressure

Providers must obtain a blood pressure reading at each well child visit beginning at three years of age.

Head Circumference

This measurement is required at each well child visit through 24 months of age.

Height and Weight

Height and weight must be measured each time the provider conducts a well child visit, with good practice requiring graphing of the measurements. **NOTE:** A suitable graphing document may be found at http://www.cdc.gov/growthcharts.

SENSORY SCREENING

Hearing - Newborn

ALL newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods.

This screening must be accomplished in one of the following ways:

- If the hospital delivered 15 or more Medicaid-covered babies between October 1, 1997 and September 30, 1998, the hospital MUST provide newborn hearing screenings for Medicaid-covered newborns using the policies and procedures recommended by the AAP. If the newborn fails the first screening, another shall be conducted prior to the newborn's discharge. **NOTE:** Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay.
- If the hospital delivered fewer than 15 Medicaid-covered babies between October 1, 1997 and September 30, 1998, the following options are available:

  The hospital may obtain the appropriate equipment and train staff to perform newborn hearing screenings using the policies and procedures recommended by the AAP. If the newborn fails the first screening, another shall be conducted prior to the newborn's discharge. **NOTE:** Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay.

  Beneficiaries Under Fee-for Service

  If the hospital delivered fewer than 15 Medicaid-covered babies and is not equipped for EOAE and/or ABR, the child's physician, nurse-midwife, or nurse practitioner shall be made aware of this fact so the newborn can be referred to a Medicaid-enrolled hearing and speech center for screening prior to one month of age.

Beneficiaries Enrolled in an MHP or SHP

If the hospital delivered fewer than 15 Medicaid-covered babies and is not equipped for EOAE and/or ABR, the child's primary care provider (physician, nurse-midwife, or nurse practitioner) shall be made aware of this fact so the child can receive an appropriate referral for screening prior to one month of age.

Hearing - Preschool

Subjective hearing screening (i.e., by history) must be performed at each well child visit.

Objective screening may be performed by the primary care provider or referred to the local health department. A Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the local health department for objective hearing screening. The results must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.

Hearing - School Age

Subjective hearing screening (i.e., by history) must be performed at each well child visit. Children with symptoms or risk factors should be referred to a hearing and speech center, an otologist, or CSHCS-sponsored otology clinic at a local health department for further objective testing or diagnosis.

Hearing - All Ages

For children of any age, a subjective hearing screening (i.e., by history) must be performed at each well child visit. Referral to a hearing and speech center, an otologist, or CSHCS-sponsored otology clinic at a local health department should be made if there are symptoms (e.g., parent or caregiver has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification.

Vision

Providers must perform a subjective vision screening (i.e., by history) at each well child visit. For asymptomatic children three years of age and older, objective screening must occur as indicated on the periodicity schedule. For children of any age, referral to an optometrist or ophthalmologist must be made if there are symptoms or other medical justification.

Vision - Preschool

Since most children cannot cooperate prior to three years of age, the standard screening is subjective. Objective screening should begin at age three. Referrals for objective vision screening by the local health department may be made directly by the primary care provider or a Head Start agency (with approval from the child's primary care provider). The results must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.

Vision - School Age

Subjective vision screening must be performed at each visit; objective screening shall be performed as indicated on the periodicity schedule.

DEVELOPMENTAL/BEHAVIORAL ASSESSMENT

Screening for development and behavior is accomplished by observation, history, and appropriate physical examination. The provider may administer a:

- standardized developmental instrument such as the Developmental Screening Test II or Bayley Scales of Infant Development.
- mental health screening.
- substance abuse screening.

If suspected problems are observed, specific objective testing must be administered either directly by the primary care provider or referred as appropriate.

INSPECTIONS

Dental

The dental health of beneficiaries depends a great deal on the child's primary care provider. Therefore, the MDCH requires providers to stress the importance of preventive and restorative dental care and adhere to the following:

- The oral cavity must be inspected at each well child visit regardless of whether teeth have erupted.
- Beginning at three years of age (younger if the individual child exhibits needs) it is extremely important that the child see a dentist every six months for prophylaxis and other preventive care. If the child does not have his/her next preventive dental appointment scheduled, the provider must make a referral. When restorative dental care is needed, the child must be referred for treatment.

Physical Examination

A complete physical examination must be performed at each well child visit. Infants are to be totally unclothed; all other children must be undressed and suitably draped.

PROCEDURES - GENERAL

Anticipatory Guidance

Anticipatory guidance explains any and all changes that will most likely occur before the next recommended well child visit, and offers strategies for dealing with the anticipated changes. This applies to all aspects of the child's life (e.g., physical, developmental, nutritional, psychosocial).

Hematocrit or Hemoglobin

The child's hematocrit or hemoglobin must be tested according to the periodicity schedule.

Hereditary/Metabolic Screening

As required by law, hospitals must test newborns for biotinadase, congenital adrenal hyperplasia, galactosemia, hemoglobinopathies, hypothyroidism, maple syrup urine disease, phenylketonuria (PKU), and sickle cell. If sickle cell testing is appropriate (as explained on the periodicity schedule), a capillary blood sample may be mailed to the Sickle Cell Detection and Information Center. Tubes, forms, and envelopes may be obtained from the Center.

Injury Prevention

Injury prevention must be discussed at each well child visit.

Interpretive Conference

The interpretive conference explains the results of the well child visit. Depending on the age and/or family status of the beneficiary, the conference may be held directly with the beneficiary, the beneficiary and parent/guardian, or only with the parent/guardian.

If a beneficiary has a potential or apparent abnormality, the provider is responsible for providing or referring for follow-up diagnostic services and treatment.

Nutritional Assessments

Nutritional assessments must be based on height, weight, and their relatedness; the most recent hematocrit/hemoglobin value; physical examination; and health history. Age appropriate nutrition counseling must be provided at each visit.

Sleep Position Counseling

Positioning of infants through six months of age for sleep must be discussed at each visit. Healthy infants should be placed on their backs; side positioning is a reasonable alternative but has a slightly higher risk of Sudden Infant Death Syndrome (SIDS).

Urine Testing

A urinalysis (at a minimum, via dipstick) must be performed for all beneficiaries at five years of age and for sexually active male and female adolescents.

Violence Prevention

Prevention of violence must be discussed at each visit.

PROCEDURES – CHILDREN AT HIGH RISK

Cholesterol

High risk children should be tested according to current AAP guidelines. Beginning at two years of age, children with the following risk factors must be screened if:

- parents or grandparents, at <55 years of age, underwent diagnostic coronary arteriography and were found to have coronary atherosclerosis. This includes those who have undergone balloon angioplasty or coronary artery bypass surgery. Perform a fasting lipoprotein analysis.
- parents or grandparents, at <55 years of age, had a documented myocardial infarction, angina pectoris, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death. Perform a fasting lipoprotein analysis.
- a birth parent has an elevated blood cholesterol level. Perform a random serum cholesterol.

If a family history cannot be ascertained and other risk factors exist, testing is at the provider's discretion.

Diabetes (Type 2)

High risk children must be tested according to the current AAP guidelines.

Beginning at age ten (or at the onset of puberty, if it occurs at a younger age), a risk assessment must be performed at each well child visit. Children at risk should be tested using the fasting plasma glucose, two-hour oral glucose tolerance, or two-hour plasma glucose tests.

A child is considered high risk if he/she is overweight (i.e., body mass index >85th percentile for age and sex, weight for height >85th percentile, or weight >120% of ideal for height) **AND** has any two of the following factors:

- has a family history of type 2 diabetes in first- and second-degree relatives
- belongs to a certain race/ethnic group (American Indian, African-American, Hispanic, Asian/Pacific Islander)
- has signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome).

Pelvic Exams, Pap Smears, Breast Exams, Counseling, and Risk Factor Interventions

Beginning at puberty, all females must receive clinical breast exams and be taught self-breast examination.

All sexually active females must have a pelvic, Pap smear, and breast exam as indicated on the periodicity schedule. Pelvic exams and Pap smears must be offered to all females 18 years of age and older. Whenever a pelvic ePxam is provided, a breast exam, counseling, and risk factor interventions must be provided.

Sexually Transmitted Diseases (STDs)

All sexually active patients must be screened for STDs according to the periodicity schedule.

Tuberculosis (TB) Testing

The CMS recommends that children be tested for TB according to the guidelines of the AAP, which is based on risk. A risk assessment must be completed at each visit. **NOTE:** For assistance in determining high risk and testing, providers may refer to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, or contact the Michigan Department of Community Health's Communicable Disease and Immunization Division.

Based on current standards of good practice, Mantoux testing is the preferred testing method.

Blood Lead

All Medicaid-covered children are considered at high risk for blood lead poisoning. The CMS has mandated that these children be tested at 12 and 24 months of age. In addition, CMS mandates that if a Medicaid-covered child is between the ages of 36 and 72 months of age and has not previously been tested for blood lead, he/she MUST be tested. **NOTE:** If the parent or guardian is unsure if the child was previously tested, he/she must be tested.

For children who have been tested, the following questions are intended to assist physicians and nurse practitioners in determining if further testing is necessary in addition to that completed at the mandated ages.

- Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint? This could include day care, preschool, or home of a relative.
- Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?
- Does the child have a brother or sister (or playmate) with lead poisoning?

- Does the child live with an adult whose job or hobby involves lead? **NOTE:** The chart following these questions presents examples.
- Does the child's family use any home remedies that may contain lead? **NOTE:** The chart following these questions presents examples.

Possible Means of Exposure:

OCCUPATIONAL
auto repair
radiator repair
battery manufacturing or repair
bridge reconstruction worker
construction worker
plumber, pipe fitter
police officer)
migrant farm worker
printing
glass manufacturing
chemical manufacturing
plastics manufacturing
rubber products manufacturing
steel welding and cutting
industrial machine operator)

OTHER
Asian cosmetics
folk remedies and/or food additives
(e.g., Greta, Azarcon, pay-loo-ah, ghasard,
Hai ge fen, Bali Goli, Kandu, Kohl, X-yoo-Fa,
Mai ge fen, poying tan, lozeena)

HOBBIES
car or boat repair
casting lead figures (e.g., toy soldiers)
painting
furniture refinishing
jewelry and pottery making
stained glass making
lead soldering (e.g., electronics)
making lead shot, fishing sinkers, bullets
target shooting at firing ranges
brass/copper/aluminum processing

ENVIRONMENTAL
ceramicware/pottery
lead crystal
lead-soldered cans (imported)
lead paint
lead-painted homes
renovating/remodeling older homes
burning lead-painted wood
use of water from lead pipes
living near lead-related industries
soil/dust near industries and roadways

Publications and other materials concerning blood lead may be obtained from the MDCH Childhood Lead Poisoning Prevention Program. The State of Michigan laboratory can also be contacted.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CHILDHOOD LEAD POISONING PREVENTION PROGRAM
PO BOX 30195
LANSING MI 48909
(517) 335-8885

State of Michigan Laboratory: (517) 335-8244

If you have questions about blood lead testing or treatment, there are pediatricians in your area who have expertise in the treatment of blood lead and are available to discuss blood lead issues with you. Please call the Childhood Lead Poisoning Prevention Program to obtain the names and telephone numbers of these pediatricians.

For blood lead analysis, the blood sample may be obtained via the capillary method (i.e., heel prick or finger stick) or venipuncture. The sample may be sent to the Michigan Department of Community Health, Blood Lead Laboratory or to any laboratory qualified to do blood lead testing. If the State laboratory is used, blood lead supplies may be obtained by calling (517) 335-9867 or (517) 335-8244.

Michigan has established a statewide blood lead registry. This requires that certain information accompany each blood lead specimen (or request, if the specimen is drawn elsewhere) to the laboratory.

- Before you begin sending blood lead samples to the State of Michigan Laboratory, you must obtain a "Submitter Clinic Code." If you send blood lead samples to the State of Michigan Laboratory, you must use form DCH-0696, Blood Lead Sampling Request. Providers may obtain a Submitter Clinic Code and a supply of the DCH-0696 by calling the Michigan Department of Community Health, Bureau of Laboratories at (517) 335-9490.
- If you send blood lead samples to a private laboratory or if the private laboratory draws and tests the sample, you may copy the DCH-0395 (Michigan Department of Community Health Blood Lead Analysis Report) for use or you may develop your own form IF all of the information from the DCH-0395 is included. When testing is completed, the laboratory completes the information contained in Part III of the form and submits it to the registry.

Primary care providers must draw blood in their offices for all children needing blood lead testing. There may be instances when a blood draw is not accomplished. If this occurs and the child resides in a jurisdiction where the local health department agrees to obtain a blood sample for blood lead testing, the primary care provider may refer a child to the local health department for the service.

The State of Michigan Laboratory will report all results to the child's ordering provider if information about the ordering provider is included. When ordering provider information is not available, results will be sent to the appropriate local health department.

If the results of a capillary blood lead sample indicate an elevated value, a confirmatory venous sample must be obtained. Capillary and venous blood lead value/action charts follow.

If the results of a capillary blood lead sample indicate an elevated value, a confirmatory venous sample must be obtained. Capillary and venous blood lead value/action charts follow.

BLOOD LEAD (Pb) INTERPRETATION

Capillary (Microblood) Samples

Pb Result (micrograms per deciliter of blood)	Action
≤ 9	No action needed.
10 – 14	Obtain **venous sample within one month**. Emphasize the importance of the venous confirmation.
15 -19	Obtain **venous sample within two weeks**. Emphasize the importance of the venous confirmation.
20 - 44	Obtain **venous sample within one week**. Emphasize the importance of the venous confirmation.
45 – 69	Obtain **venous sample within 48 hours**. Emphasize the importance of the venous confirmation.
≥ 70	Obtain **venous sample IMMEDIATELY**. Emphasize the importance of the venous confirmation.
N.R. (no results-insufficient or clotted blood)	Repeat capillary sample one time **OR** obtain venous sample.

KEY: ≤ = less than or equal to

≥ = greater than or equal to

NOTE: For values above 9, the provider shall always provide general health education to the parents regarding nutrition, house-cleaning techniques, and lead poisoning prevention. (This is considered part of the interpretive conference and is not separately reimbursable.)

BLOOD LEAD (Pb) INTERPRETATION

Venous (Macroblood) Samples

Pb Result (micrograms per deciliter of blood)	Action
≤ 9	No action needed.
10 – 19	Refer **within one month** for medical evaluation and retesting. The provider shall contact the local health department to determine if resources are available to provide follow-up services for this Pb range.
20 – 44	Refer **within five working days** for a complete medical evaluation. Refer to the local health department **within ten working days** for blood lead poisoning follow-up services.
45 – 69	Refer **within 48 hours** for medical intervention. Refer to the local health department **within five working days** for blood lead poisoning follow-up services.
≥ 70	Refer **IMMEDIATELY** for a complete medical evaluation. Refer to the local health department **within 24-48 hours** for blood lead poisoning follow-up services.
N.R. (no results-insufficient or clotted blood)	Repeat venous sample.

KEY: ≤ = less than or equal to

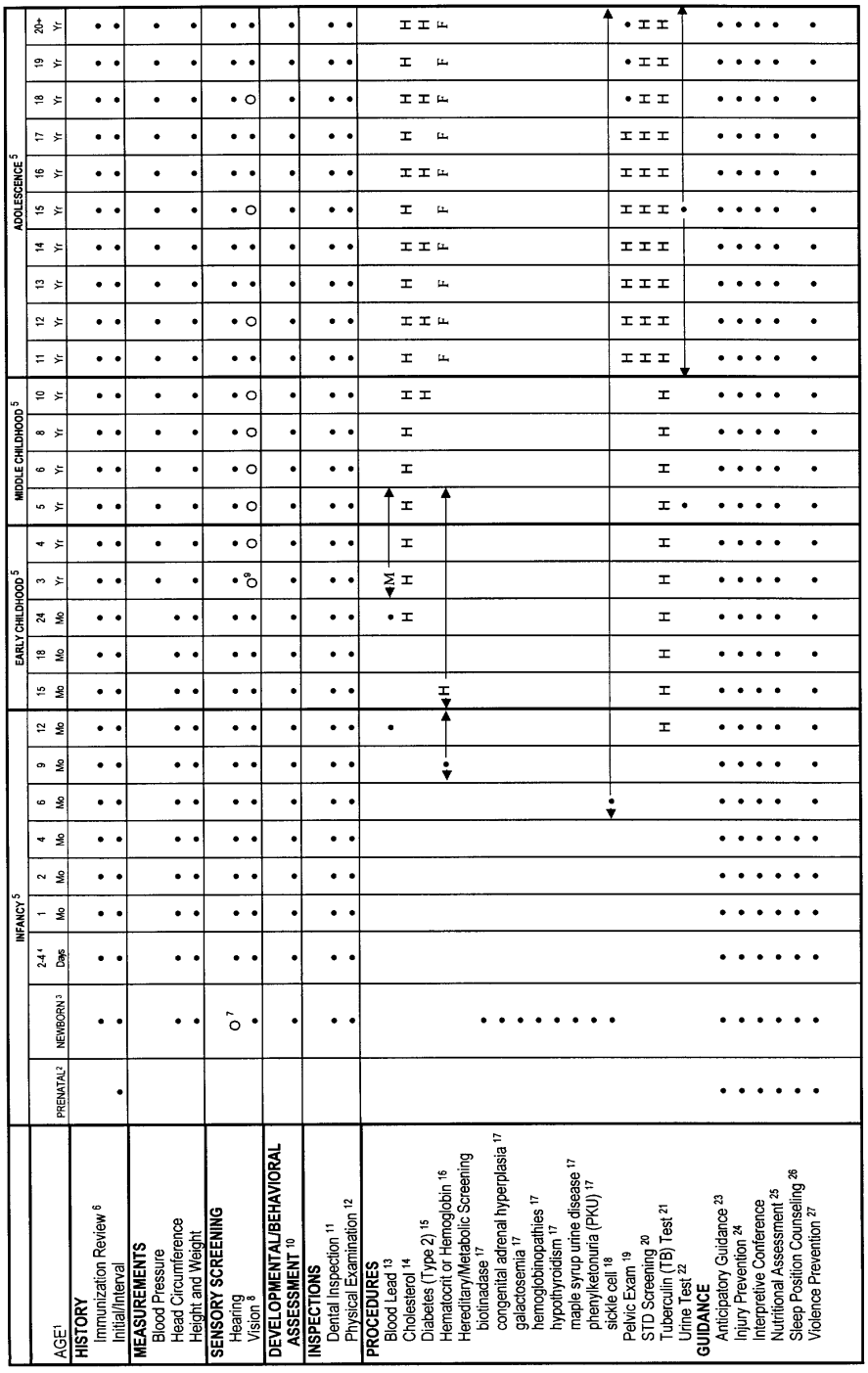
≥ = greater than or equal to

NOTE: For values above 9, the provider shall always

- emphasize the importance of following through with any retesting, evaluation, or intervention.
- provide general health education to the parents regarding nutrition, house-cleaning techniques, and lead poisoning prevention. This is considered part of the interpretive conference and is not separately reimbursable.

EPSDT PERIODICITY SCHEDULE

EPSDT COMPONENTS BY AGE OF BENEFICIARY



Back

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include pertinent medical history, injury prevention, and anticipatory guidance. The benefits of breastfeeding should be discussed as well as the planned method of feeding per AAP statement "The Prenatal Visit" (RE0053), Pediatrics, Volume 107, Number 6, June 2001, pp. 1456-1458.
3. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (RE9729), Pediatrics, Volume 100, Number 6, December 1997, pp. 1035-1039.
4. For newborns discharged within 48 hours of delivery, per AAP statement "Hospital Stay for Healthy Term Newborns" (RE9539), Pediatrics, Volume 96, Number 4, October 1995, pp. 788-790.
5. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
6. An immunization review shall be performed at each appointment, with immunizations being administered at appropriate ages, or as needed. See schedules published annually in the January edition of Pediatrics.
7. **ALL** Medicaid-covered newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods per AAP statement "Newborn and Infant Hearing Loss: Detection and Intervention" (RE9846), Pediatrics, Volume 103, Number 2, February 1999, pp. 527-530.
8. A subjective vision screening (i.e., by history) shall be performed at each appointment. For asymptomatic children three years of age and older, objective screening shall occur as indicated. For children of any age, a referral to an optometrist or ophthalmologist shall be made if there are symptoms or other medical justification.
9. If the patient is uncooperative, rescreen within six months.
10. By history and appropriate physical examination and/or via a screening instrument. If suspicious, by specific objective developmental, mental health, or substance abuse testing. Parenting skills should be fostered at every visit.
11. A dental inspection should be performed at each screening. Provide reinforcement of routine preventive dental care, stressing the recommended schedule of the American Academy of Pediatric Dentistry. If the next preventive dental visit is not scheduled, if the beneficiary does not have a dentist, or if restorative dental care is needed, a referral shall be made.
12. A complete physical examination shall be performed at each appointment. Infants should be totally unclothed, older children undressed and suitably draped.
13. Medicaid children are considered high risk and shall be tested accordingly. Information relative to testing, treatment, and referrals may be obtained by calling the Childhood Lead Poisoning Prevention Program at (517) 335-8885.
14. Test high risk children per AAP statement "Cholesterol in Childhood" (RE9805), Pediatrics, Volume 101, January 1998, pp. 141-147. If a family history cannot be ascertained and other risk factors are present, testing is at the discretion of the provider.
15. Test high risk children every two years beginning at ten years of age (or at onset of puberty if it occurs at a younger age). Refer to the AAP statement "Type 2 Diabetes in Children and Adolescents, Consensus Statement of the American Diabetes Association" in Pediatrics, Volume 105, March 2000, pp. 671-680.
16. See AAP *Pediatric Handbook of Nutrition* (1998) for a discussion of universal and selective screening options. Consider earlier screening for high risk infants (premature infants, low birth weight infants). Also see "Recommendations to Prevent and Control Iron Deficiency in the United States" *MMWR*, 1998; 47 (RR-3):1-29.
17. By law, these newborn tests should be initiated before the child is discharged from the hospital.
18. If the child was born in a Michigan hospital on or after October 1, 1987, the test should have been performed on the newborn. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least six months of age and the results are known to the parent.
19. All sexually active females (high risk) shall have a pelvic exam and Pap smear. A pelvic exam, breast exam, and Pap smear should be offered to all females beginning at 18 years of age.
20. All sexually active patients (high risk) shall be screened for sexually transmitted diseases (STDs).
21. Test high risk children according to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Based on standards of good practice, Mantoux testing is the preferred method.
22. A urinalysis (at a minimum, via dipstick) for all children at five years of age and for sexually active male and female adolescents.
23. Age-appropriate discussion and counseling should be an integral part of each visit per the AAP "Guidelines for Health Supervision III" (1994).
24. From birth to 12 years of age, refer to the AAP injury prevention program as described in *A Guide to Safety Counseling in Office Practice* (1994).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Pediatric Handbook of Nutrition* (1998).
26. Parents and caregivers shall be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of Sudden Infant Death Syndrome (SIDS). Consult the AAP statement "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position" (RE9946), Pediatrics, Volume 105, Number 3, March 2000, pp. 650-656.
27. Violence prevention and management per AAP statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (RE9832), Pediatrics, Volume 103, Number 1, January 1999, pp. 173-181.

If any problems are detected or suspected, a referral should be made.

If a test is contraindicated at the time of appointment, it need not be performed; if the provider wishes to perform certain tests more frequently (e.g., take blood pressure at each visit, test an older child for blood lead), they may be provided; or if the child requires more frequent health checkups, they may be provided. If additional tests are required, they may be performed or referred, as appropriate.

REFERRALS

If a problem is found or suspected during a well child visit, the (suspected) problem must be diagnosed and treated as appropriate. This may mean referral to another provider or a "self referral" for further diagnosis and treatment. Referrals must be made based on standards of good practice and the MDCH's established periodicity schedule or presenting need, if outside the normal schedule.

When a fee-for-service provider performs medically necessary treatment involving diagnostic or therapeutic procedures beyond examination of the child (e.g., wart removal) for a condition found during a well child visit, these procedures are covered in addition to the well child visit. Other medical visits/examinations are not covered separately if performed on the same date of service as the well child visit by the same provider. If the provider cannot perform the needed treatment, a referral must be made to an appropriate provider. If you are not familiar with providers in the area, the local health department can assist you with referrals.

MHP and SHP providers must follow the referral procedures for the specific plan in which the beneficiary is enrolled.

Psychiatric (e.g., suspected behavioral disorder)

A full range of psychiatric services is available for Medicaid-covered fee-for-service beneficiaries under 21 years of age from a Community Mental Health Services Program (CMHSP).

The MHP and SHP contracts include a limited mental health benefit coverage for beneficiaries with mild/moderate mental health conditions;however, CMHSPs are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries with more significant, persistent, complex, and/or serious psychiatric conditions.

Women, Infants and Children (WIC)

The Women, Infants and Children (WIC) program located at local health departments, Indian tribal clinics, and federally-funded clinics is a special supplemental feeding program that provi des food coupons and nutritional education to eligible children under five years of age and pregnant women. The provider is expected to make referrals to a WIC site for eligibility determination.

Other Programs

Other programs exist that could benefit Medicaid beneficiaries, such as Head Start, intermediate school district services, genetics counseling, nutrition programs, and public health nursing. The provider is encouraged to become familiar with available programs and make full use of them whenever referrals are appropriate.

Blood Lead Poisoning Follow-Up Services

Many local health departments provide blood lead poisoning follow-up services, which consist of environmental investigations and nursing assessment/investigation visits. The provider must contact the local health department to determine if services are available in the area and the blood lead levels at which referrals are accepted.

Local health departments may provide blood lead poisoning follow-up services provided to any Medicaid-covered child, regardless if the child is enrolled with an MHP, SHP, or is in the fee-for-service program. Authorization for these services is not required by the MHP/SHP; however, local health departments must notify the plan of the service(s) provided and provide the plan with a summary of each.

Documentation of the child's blood lead poisoning level that initiated service must be maintained, as well as documentation of all environmental investigations and nursing assessment/investigation visits.

Environmental Investigations

Environmental investigations are covered for the local health department if the health officer from the local health department completes a copy of the Blood Lead Poisoning Follow-Up Services Assurance Of Provision form (DCH-1530). The form must be mailed to:

PROVIDER ENROLLMENT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30238
LANSING MI 48909

If more than one child in the home has blood lead poisoning, the local health department must select one child's Medicaid ID Number and report a single initial and a single follow-up environmental visit.

Initial Environmental Investigation

A risk assessor certified by the State of Michigan's Lead Hazard Remediation Program must conduct the investigation of the child's home. If necessary, an investigation may be covered at a second site if the child spends time regularly at that site and it is a possible source of lead exposure. The MDCH will cover a maximum of two such investigations per episode of blood lead poisoning.

The investigation must follow the "Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels" and risk assessment activities per the Lead Abatement Act of 1998. The investigation must include the testing of appropriate potential sources of paint, house dust, soil, water, and other household risk factors such as pottery and home remedies. Education must be provided regarding known and potential sources of lead poisoning, reduction of future exposures, and suggestions for specialized cleaning techniques.

The risk assessor must prepare a risk assessment report per rule R325.9916 promulgated pursuant to the Lead Abatement Act that will include lead hazard control recommendations and the potential relocation of the child depending upon the severity of the lead hazards found.

Discussion with the family must include agencies that may be able to provide assistance with lead hazard control recommendations provided in the risk assessment report.

An episode includes a venous blood sample indicating the child is at risk according to recommendations of the Centers for Disease Control and Prevention, and also includes resulting treatment and follow-up services.

Follow-up Environmental Investigation

The MDCH covers one follow-up environmental investigation per episode of poisoning to determine if lead hazard control interventions were performed satisfactorily and verified by a visual inspection and dust wipe clearance sampling. However, if a second site was investigated as the possible source of lead exposure and had lead hazard control interventions performed, the MDCH also covers a follow-up environmental investigation performed at that second site.

Environmental Investigation Resource Documents

Providers may obtain the "Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels", a list of certified risk assessors, applications for training and certification, and education materials from:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
LEAD HAZARD REMEDIATION PROGRAM
PO BOX 30195
LANSING MI 48909 Phone: (517) 335-9390

Nursing Assessment/Investigation Visits

The MDCH covers up to two nursing assessment/investigation visits per episode of blood lead poisoning. If more than one child in the home has blood lead poisoning, the nursing assessment/investigation visits are covered for each child.

The blood lead nursing visits must be provided in the child's home. For beneficiaries enrolled under fee-for-service, the visits may be conducted by an enrolled home health agency, a local health department or other medical clinic, or a physician. **NOTE:** This procedure is not covered for Maternal Support Services and Infant Support Services providers.

Blood lead nursing visits provided through a MHP or SHP are covered by the individual MHP or SHP.

The first nursing assessment/investigation visit focuses on:

- assessment of the growth and developmental status of the child, including any symptomatology that may be present in the child
- behavioral assessment of the child, including any aggressiveness and/or hyperactivity
- nutritional assessment of the child
- assessment of typical family practices that may produce lead risk (e.g., hobbies, occupation, cultural practices)
- limited physical identification of lead hazards within the dwelling
- identification and planning for testing for any other family member at risk for sequelae of lead hazard exposure
- education and information regarding lead hazards and ways to minimize those risks in the future
- development of a family plan of care to increase the safety of the child from lead hazards

The second blood lead nursing visit focuses on:

- reinforcement of the educational information presented to the family during the first visit
- validation of the family's ability to carry out activities to minimize risks of continued lead exposure
- modifications of the plan to minimize lead risks, as needed

Blood Lead Resource Documents

Providers are encouraged to review "Guidelines for Environmental and Nursing Investigations for Children with Elevated Venous Blood Lead Levels" and apply these standards. This publication, plus other materials concerning blood lead poisoning, may be obtained from:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CHILDHOOD LEAD POISONING PREVENTION PROGRAM
PO BOX 30195
LANSING MI 48909 Phone: (517) 335-8885

GENERAL PRACTICE

ALLERGY TESTING AND IMMUNOTHERAPY

Allergy testing and immunotherapy services are covered by the Program. Testing is covered under the appropriate CPT/HCPCS code with the appropriate quantity as indicated by the code description. A visit is covered in addition to the testing. Coverage of the testing includes the interpretation of the testing results in relation to the history and physical examination of the beneficiary.

Immunotherapy services are covered under the appropriate CPT/HCPCS component codes. The services of the provider who actually prepares and provides the antigens/venoms are covered on a per dose basis. The services of the provider who parenterally administers the antigen/venom are covered under the appropriate injection codes. The injection and the antigen/venom preparation services are covered separately.

Allergy injection services are not covered in addition to the visit unless the visit represents another significant, separately identifiable service above and beyond the antigen/venom immunotherapy and the appropriate modifier is reported.

The Program assumes antigens are prepared to be administered over a period of time in increasing doses. Antigens are covered at the same rate per dose regardless of whether multiple or single dose vials are used. The Program covers the dose administered and the preparation of the dose administered.

Any allergy testing and treatments that have not been proven to be effective are **not** covered.

AMBULANCE SERVICES

Coverage for ambulance services is restricted to medically necessary and appropriate services when medical/surgical or psychiatric emergencies exist or no other effective or less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Emergency ambulance services do not require a physician’s order.

The physician must order all non-emergency, medically necessary ambulance transportation. The physician’s order must contain the following information:

- Beneficiary’s name and Medicaid ID number, and
- Medical necessity of an ambulance transport, and
- Physician’s signature and Medicaid Provider ID number.

The physician is responsible for providing documentation of the medical necessity of the ambulance transport to the ambulance provider for their files. A physician may write a single prescription for the non-emergency ambulance transport of a beneficiary with a chronic condition to planned treatments for a period up to one month. The prescription must include the type of transport necessary, why other means of transport could not be used, the frequency of needed transport, origin, destination, diagnosis, and medical necessity for the transport. For all other non-emergency transport, a separate physician’s order is required for each individual transport.

The provider is referred to Chapter III of the ambulance manual for additional specific information related to ambulance transportation.

AUDIOLOGICAL AND HEARING SERVICES

The Program covers hearing evaluations and other audiological function testing by a physician. Hearing evaluations are covered when they include pure-tone audiometry, speech audiometry, and a report of findings.

A hearing aid is covered if all of the following criteria are met:

- The physician performs an evaluation within six months prior to the beneficiary obtaining a hearing aid.
- The evaluation reveals that the beneficiary needs a hearing aid and that there is no contraindication to the use of a hearing aid.
- The physician prescribes a hearing aid.
- The beneficiary presents the prescription and a written statement of the evaluation to an enrolled hearing and speech center.
- The enrolled hearing and speech center determines the type of hearing aid that is needed.
- The beneficiary is referred to an enrolled hearing aid dealer for provision of the aid.

Newborn Hearing Screening

The Program requires that all Medicaid-covered newborns be screened using the automated auditory brainstem response (ABR) method and/or the automated evoked otoacoustic emissions (EOAE) method.

Results must be reported to the child's primary care provider in a timely manner.

If the birthing hospital has the appropriate equipment, the screening must be done at the hospital. When this occurs, the screening is covered as a part of the inpatient stay.

If the hospital is not equipped for ABR or EOAE, the child's physician, certified nurse midwife, or nurse practitioner must refer the newborn to a Medicaid enrolled hearing and speech center for screening prior to one month of age.

Local Health Department Screenings

The primary care provider or Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the local health department for objective hearing screening. The results of the screening must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.

The Program will monitor the number of MHP and SHP referrals reported by local health departments, and may initiate charge-backs to the plans.

CARE OF ABUSED CHILDREN

The Program covers physician services related to the diagnosis and treatment of suspected abused or neglected children. When the physician has reasonable cause to suspect that a child may have been abused or neglected, he/she must immediately contact the appropriate Protective Services Unit of the local office of the Family Independence Agency to report his/her suspicions.

The Program covers the inpatient stay of an abused or neglected child when, upon admission, the attending physician determines that the child requires further assessment and treatment which is best provided on an inpatient basis.

NOTE: The physician cannot admit a child to the hospital for the sole purpose of custodial or protective care.

CHILDBIRTH/PARENTING EDUCATION

The Program covers childbirth/parenting education for pregnant women when referred in writing by the prenatal care provider and provided by qualified educators in a Medicare certified outpatient hospital or by a certified maternal support service (MSS) program provider.

This service is not covered if rendered by the prenatal care provider in the office setting.

CHILDREN'S MULTIDISCIPLINARY SPECIALTY CLINIC SERVICES

The Program covers Children's Multidisciplinary Specialty Clinic services for Medicaid beneficiaries under age 21 and all Children's Special Health Care Services (CSHCS) beneficiaries who have qualifying medical conditions. Children's Multidisciplinary Specialty Clinic services are reserved for beneficiaries whose medical condition(s) is/are of severe and chronic or disabling nature and require complex coordinated assessment and management.

Children's Multidisciplinary Specialty Clinics provide a coordinated interdisciplinary approach to the management of specific complex medical diagnoses. Services are provided by a team of pediatric specialty physicians and a complement of other health professionals.

The Children's Multidisciplinary Specialty Clinics provide:

- opportunity for organized communication among specialty providers to ensure efficient coordination and of services,
- clear statements of current comprehensive assessments and ongoing treatment plans,
- an integration point for communication and coordination with community-based care providers and other community facilities that are tailored to beneficiary's needs, and
- opportunity to encourage the parents and the child to participate in treatment planning, allowing for timely feedback and discussion of concerns with specialists.

A Children's Multidisciplinary Specialty Clinic must be enrolled as an outpatient hospital facility and be specifically approved by the Michigan Department of Community Health (MDCH) to provide Children's Multidisciplinary Specialty Clinic services to Medicaid and CSHCS beneficiaries.

COMMUNICABLE DISEASE TREATMENT

The Program covers the diagnosis and treatment of communicable diseases including tuberculosis, hepatitis, meningitis, and enteric disease. **Cases of communicable disease must be reported to the local health department.** Providers may obtain additional information regarding communicable disease prevention and control from the local health department.

DIABETES PATIENT EDUCATION

The program covers diabetes self-management education when ordered by a physician and provided by diabetes educators (e.g. nurse, dietitian) in a Medicaid enrolled outpatient hospital or a local public health department which has been certified by Community Public Health (CPH).

This service is not covered if rendered by a physician in the office setting, rendered by a non-enrolled provider, or rendered by a non-CPH certified provider.

DIAGNOSTIC TESTS

The Program covers tests to diagnose a disease or a medical condition. Diagnostic testing must be directly related to the presenting condition of the beneficiary.

FAMILY PLANNING

Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis) are covered by the Program. A visit for family planning typically includes a complete physical examination including a pelvic examination.

Separately identifiable services provided in addition to the examination are covered separately. Counseling for family planning services, including sterilization, is covered as a part of the family planning visit.

Contraceptives

The Program covers contraceptives including:

- oral contraceptives (must be prescribed by a physician and dispensed by an enrolled pharmacy or family planning clinic.)
- diaphragms
- intrauterine devices
- condoms (available from a pharmacy without a prescription, or from a family planning clinic.)
- foams, gels, sponges (must be prescribed by a physician and dispensed by a pharmacy or family planning clinic.)

FOOT CARE, ROUTINE

The Program covers these services when provided by a physician or podiatrist and when the beneficiary manifests signs and symptoms from a specific systemic disease of sufficient severity that care by a nonprofessional would be hazardous. The medical necessity for these services must be documented in the beneficiary's medical record and the beneficiary must be receiving regular care from a physician for the systemic disease.

FRACTURE CARE

The Program covers medically necessary fracture care. Coverage includes the initial traction, cast application and removal, and routine follow-up care. Refracture or re-reduction are independent procedures not included in the original treatment and are covered separately.

Fracture care includes the insertion and removal of necessary wires, pins, etc. If the wire, pins, etc., are the type that are not normally removed but the removal is medically necessary, Medicaid will also cover such removal. Documentation of the need must be included on the claim.

Coverage also includes **subsequent recasting** required during the course of fracture treatment (i.e., following initial cast application). The Program covers of cast removal as a separate service **only** when performed by a physician who was not involved in the fracture care and who is not reapplying another cast.

IMMUNIZATIONS (VACCINES AND TOXOIDS)

Vaccines and toxoids (immunizations) are covered when given according to ACIP (Advisory Committee on Immunization Practices) recommendations. For Medicaid children under the age of 19 years old, the VFC (Vaccine for Children) Program provides covered vaccines at no cost to the provider. In addition, Michigan offers a similar program for Medicaid adults 19 years old and older called the MI-VRP (Michigan Vaccine Replacement Program). Td, MMR, and Hepatitis B for adults are available from the local health department at no cost to the provider. Any local health department in the state can be contacted for specifics about the VFC and MI-VRP

program, what vaccines are available, and instructions on enrolling and obtaining vaccines. The Program will not cover vaccine costs for any product available free for Medicaid enrollees.

An administration fee is covered separately for vaccines and toxoids given to Medicaid beneficiaries whether the vaccine is free or not, and without regard to other services provided on the same day. The administration fee is set for each immunization.

For vaccines and toxoids available free under the VFC program, Federal statutes limit the amount a provider can charge for the administration of the vaccine. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private pay patient is $5.00, then the charge for vaccine administration to the Medicaid patient cannot exceed $5.00.

The Program encourages providers to immunize all Medicaid beneficiaries according to the accepted immunization schedule. For Medicaid beneficiaries enrolled in a Medicaid Health Plan, the health plan must ensure that the Medicaid enrollees receive complete and timely immunizations. When a provider contracts with a health plan to provide primary care (which includes immunizations), then the provider must immunize the patients assigned to him/her by the plan. Medicaid Health Plans must not refer beneficiaries to a local health department for immunizations.

If a beneficiary is in a nursing facility, the facility is responsible for appropriately immunizing the residents. Coverage of the immunizations is included in the payment made to the facility.

INJECTABLE DRUGS AND BIOLOGICALS

The Program covers injectable drugs and biologicals administered by a physician in the office or clinic setting and the beneficiary's home. The drug must be FDA approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of the illness or injury of the patient.

An injectable drug is covered if the drug:

- is specific and effective treatment for the condition for which it is being given, and
- is given for the treatment of a particular documented diagnosis, illness, or condition (e.g., vitamin injections which are not specific replacement therapy for a documented deficiency or disease and are given simply for the general good and welfare of the patient), and
- is administered by the recommended or accepted administration method for the condition being treated, and
- is administered according to the recommended dosing schedule and amount for the condition being treated.

The Program covers the drug and the administration of the drug. If another covered service is provided at the same time, the administration of the drug is considered a part of that service and is not covered separately. Fee screens for the cost of the drug are established at 95% of the average wholesale price (AWP). Drug fee screens are updated quarterly.

For any injections given by the physician in the office, clinic setting, or the beneficiary's home, the injectable drug is considered a physician service rather than a pharmacy benefit. The physician must not send the beneficiary to a pharmacy to obtain an injectable drug or to have the pharmacy bill directly to the Program for injectable drugs under the pharmacy benefit if the physician is administering the drug in the office, clinic, or beneficiary's home. If a pharmacy sells injectable drug products to a physician, the pharmacy must obtain payment directly from the purchasing physician.

LABORATORY

The Program covers medically necessary laboratory tests needed to diagnose or treat a specific condition, illness, or injury. The Program also covers screenings such as pap smears, PSA, TB, etc.. Laboratory services must be ordered by a physician, podiatrist, dentist, or nurse midwife according to their scope of practice.

Required laboratory testing must be documented by the ordering physician in the patient's medical chart regardless of where the tests are performed. The ordering physician will be held responsible if he/she orders excessive or unnecessary laboratory tests regardless of who actually renders the services. He/she may be subject to any corrective action related to these services, including recovery of funds.

Ordering or rendering of "profiles" or "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition is considered random screening and is not covered. Multiple laboratory tests carried out as a part of the initial evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered.

Medical Necessity

The documentation of medical necessity must include a description of the patient's symptomatology and other findings which have led the physician to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is **not** considered documentation of medical necessity.

Referred Services

If a physician refers a beneficiary to an **outside laboratory** (independent lab, hospital lab, clinic lab, or physician office lab) for testing, the physician **must** indicate his/her seven-digit Medicaid ID Number on the referral.

A physician cannot refer a patient to an outside laboratory where he/she has a financial interest. Noncompliance may result in corrective action by the department or other agencies.

Physician laboratory services are covered when performed by him/her or by his/her employees under his/her direct supervision. Coverage for laboratory services includes the collection of the specimen(s), the analysis, and the report. The Program will perform pre and/or post payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Questionable ordering patterns may result in a prepayment review of each laboratory procedure billed or other corrective measures as a result of that provider's orders.

A beneficiary cannot be charged for any covered laboratory procedure including those that are determined to be not medically necessary or for those laboratory procedures, which exceed the laboratory daily reimbursement limit.

The Program limits laboratory payments when rendered by the same provider, for the same beneficiary, on a single date of service. Coverage is limited to only those laboratory procedures, which do not exceed the daily reimbursement limits specified in the following table.

PROVIDER DESCRIPTION	DAILY LIMIT
Practitioner, Nurse Midwife	$ 50
Podiatrist	$ 50
Family Planning Clinic	$ 50
Medical Clinic	$ 50
Independent Laboratory	$ 125
Outpatient Hospital	$ 75

Laboratory Tests Exempt From Daily Limit

The following selected laboratory services identified by CPT/HCPCS procedure codes are exempt from the daily dollar limit.

- Limited Pathology Consultation
- Comprehensive Pathology Consultation
- Bone Marrow Procedures
- Cytopathology
- Cytogenetics
- Electron Microscopy

If the coverage limits are exceeded, the billing health care provider **must** request an exception to the daily limit by submitting documentation of medical necessity for **each** laboratory procedure. All services provided on that date of service will be manually reviewed for medical necessity and payment determined accordingly.

When it is anticipated that Program payments for testing ordered from an outside laboratory will exceed the coverage limit, the ordering practitioner **must** forward medical necessity documentation to the servicing laboratory for submission with the laboratory billing.

CSHCS Coverage

The coverages defined in this section and the daily reimbursement limits do not apply to beneficiaries with only Children's Special Health Care Services (CSHCS) eligibility. The coverage limits do apply to beneficiaries with dual Medicaid and CSHCS eligibility if the laboratory procedures are not related to the crippling diagnosis.

Blood Handling

The Program reimburses for blood handling only under the following circumstances:

- A beneficiary may be referred to a laboratory, clinic, or outpatient hospital for the sole purpose of drawing, packaging, and mailing a blood sample to the Michigan Department of Community Health for blood lead analysis. In this instance, the laboratory, clinic, or outpatient hospital may bill for blood handling. The State provides lead-free vacutainers for the analysis. Requests for vacutainers and the samples for analysis should be sent to:

  Michigan Department of Community Health
  Bureau of Laboratories
  Trace Metal Section
  3350 North Martin Luther King, Blvd.
  Lansing, Michigan 48906

- A beneficiary occasionally requires blood tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that will be performing the test(s). If this is not practical (i.e., the laboratory is not a local facility) and the **sole purpose** of a visit is to draw, package, and **mail** the sample to a laboratory, the blood handling may be covered. An office visit or other service code are not covered on the same date of service as the blood handling service.

Hematology Studies

A practitioner's order for a complete blood count (CBC) with white blood cell (WBC) differential includes the RBC and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. Additional hematology testing **must** have specific practitioner orders. The ordering practitioner is responsible for documenting the medical necessity and recording the order in the beneficiary's medical record.

Microbiology Studies

Gram fluorescent/acid fast stain procedures are included in the coverage for microbiology procedures when performed on the same date of service for the same beneficiary.

Pap Smear

Coverage for obtaining the cervical smear is included as a part of the pelvic examination. Interpretation of the smear must be performed by a pathologist. The report must include the printed or typewritten name of the pathologist and his/her handwritten signature.

More than one Papanicolaou test within a 12-month period will be covered only when determined medically necessary by the attending practitioner.

Pathology Consultations

Pathology consultations performed by a hematologist/pathologist for the review of abnormal laboratory test results are covered by the Program if:

- the abnormality relates to the beneficiary's medical condition and corresponding medical care (i.e., a peripheral blood smear review must be necessary for the specific patient's care), and
- the referring physician orders the review and records the order in the patient's medical record (standing consultation orders from a physician to a laboratory are not covered by the Program), and
- a detailed report is sent to the referring physician.

The report prepared from the study performed by the hematologist/pathologist must include:

- identification of the laboratory where the review was performed;
- name of the referring physician;
- beneficiary's name;
- date of review;
- identification of material examined;
- comments and descriptions of normal and abnormal findings;
- descriptions detailed enough to support a clinical impression or diagnosis;
- clinical impression or diagnosis presented in relation to the suspected disease, disease process, or state of altered physiology;
- recommendations for investigation or therapy, if any; and
- the typewritten or printed hematologist/pathologist's name and his/her handwritten signature.

This information must be retained in the beneficiary's medical records.

Pregnancy Related Lab Services

For routine pregnancy testing, the Program covers the serum or urine HCG qualitative method.

The obstetric profile is covered when ordered by the attending practitioner as an all inclusive panel of tests for required prenatal laboratory services. The individual tests of the OB Profile are:

- ABO typing
- CBC with WBC differential
- Hepatitis B surface antigen
- RBC antibody detection
- Rh (D) typing
- Rubella antibody
- Syphilis testing

HIV testing and Urinalysis are covered separately when determined to be medically necessary and are ordered by the practitioner.

Automated and Semi-Automated Testing

The Program covers automated and semi-automated laboratory tests. Refer to the physician database for specific coverages.

Practitioner Laboratory Procedures

Clinics and office-based laboratories must be registered by the Clinical Laboratory Improvement Act (CLIA). The Program only covers the procedures contained in the CLIA Certificate of Waiver Testing list for Certificate of Waiver practitioners. Coverage includes only the procedures contained in the CLIA Certificate of Registration Testing list for Certificate of Registration practitioners. The Program covers the procedures identified in the CLIA Physician Performed Microscopy list for appropriately certified physicians. Laboratory tests covered for nurse midwives and podiatrists who have the appropriate CLIA certification, are identified in the appropriate database on the DCH website.

MYCOTIC NAILS, DEBRIDEMENT

The Program covers debridement of mycotic nails once in a 60-day period when provided during or following any appropriate course of medical treatment for the causative fungal infection. Documentation in the beneficiary's medical record must support clinical evidence of the mycosis, identification of the toe nail(s) affected, and evidence that the mycosis is likely to result in significant medical complications if appropriate antifungal treatment is not rendered.

The debridement of mycotic nails is covered for beneficiaries in the long-term care facility only on the written order of the attending physician (M.D. or D.O.). The order must be patient specific and not for routine care only.

NERVE BLOCKS

Nerve blocks are covered as a surgical procedure when performed for diagnostic or therapeutic purposes. As a surgical procedure, a complete description of the services rendered must be documented in the beneficiary's medical record. When used as anesthesia for another procedure, the anesthesia guidelines apply. Nerve blocks are not separately covered when used as a local anesthetic for another surgical procedure.

Therapeutic and Diagnostic

A nerve block is the injecting of a local anesthetic or neurolytic agent around a nerve to produce a block of that specific nerve. It is not injecting a painful area under the skin, or a trigger point, or an injection into the general muscle mass of subcutaneous tissue that does not follow the anatomy of a specific nerve, to produce temporary relief of pain in that area.

Frequency of Coverage

Nerve blocks are payable in the hospital or office setting as appropriate. No more than three nerve blocks to the same area will be covered within a six-month period without documentation of medical necessity. The documentation must include the diagnosis or condition, the management/treatment plan, the specific nerve(s) affected, the indications, and the expected benefits. A medical visit is not covered separately on the same day unless documentation is supplied to justify the separate services.

OXYGEN

The Program covers oxygen and the equipment necessary for the administration of oxygen therapy.

Gaseous cylinder oxygen may be provided by a pharmacy or a medical supplier. Portable cylinder oxygen is allowable if the cylinder can be refilled and if the flow rate is adjustable.

Concentrators, liquid oxygen, and oxygen tents may only be provided by a medical supplier. Prior authorization is required.

All oxygen and equipment requires a physician's prescription and a CMN. The initial prescription is valid for 6 months. The first follow-up prescription is valid for 6 months and each subsequent prescription is valid for 1 year.

The written prescription for oxygen must include:

- the date the oxygen was prescribed,
- the beneficiary's diagnosis(es),
- the flow rate (liters per minute),
- the number of hours to be used per day,
- duration of need,
- delivery system to be used,
- PO2 level or oxygen saturation.

The physician is referred to the medical supplier manual chapter III for additional information and specific prior authorization requirements.

SUBSTITUTE AND LOCUM TENENS PHYSICIANS

The Program covers the services of substitute physicians or locum tenens physicians and allows payment to be made to the beneficiary’s primary physician for these services. Parameters for these arrangements are determined through federal statutes and CMS requirements.

Medicaid coverage under the beneficiary's primary physician for the services of a substitute physician can only occur under the following substitute physician billing arrangements:

- An informal reciprocal arrangement for a period not to exceed 14 days.

OR

- A locum tenens or temporary arrangement for 90 continuous days in the case of a per diem or other fee-for-time compensation.

Coverage for services provided by a substitute physician under either a reciprocal billing or a locum tenens arrangement must follow Medicaid policy for the service(s) rendered. Documentation in the beneficiary's medical record must identify the physician actually providing the service.

SUPPLIES IN THE OFFICE SETTING

The Program separately covers a limited number of supplies used in the office setting. RVU-based payment to practitioners includes payment for the office overhead expense associated with the service. In most cases, the overhead includes the supplies used or provided by the provider in connection with the service. Providers must not require beneficiaries to buy a supply item in advance from a drugstore or other supplier that is necessary to use in providing the service. If a beneficiary needs supplies to use in the home, the provider should write a prescription that the beneficiary can take to a pharmacy or medical supplier to be filled. Medicaid does not cover "take-home" supplies for the office setting. Payment for any surgical dressings applied by a physician in the office or other non-facility setting is not covered separately.

In keeping with the RVU-based fee schedule, casting and splinting supplies are covered separately when used in the treatment of fractures or dislocations in the office setting. An allowance for these supplies is not included in these treatment codes. Cast/splint supplies are not covered without the appropriate fracture/dislocation codes.

The following supplies are covered separately when provided in the office setting:

- Collagen skin test kit.
- Implantable external access device.
- Levonorgestrel implant is payable in addition to the insertion procedure on the same day.
- Progestasert IUD or copper IUDis payable in addition to the insertion of the device on the same day.
- Levulan PDT.

Refer to the physician's database on the DCH website for specific supplies which are covered separately.

VISION SERVICES

The Program covers medically necessary services for the diagnosis and treatment of complaints or symptoms of an eye disease or injury. An eye exam or service is considered "routine" and subject to vision benefit co-payments and limitations if provided solely for any of the following diagnoses:

- ametropia
- anisometropia
- astigmatism

- emmetropia
- hypermetropia
- hyperopia
- myopia
- "no pathology"
- presbyopia
- refractive error

A routine examination is covered once every two years. The exam includes history, visual acuity determination, external exam of the eye, binocular measure, ophthalmoscopy with or without tonometry, with plotting of visual fields, with or without biomicroscopy (slit lamp), and with or without refraction. Exceptions to this frequency require documentation of medical necessity, including the visual acuities from both examinations. It is not sufficient to say "two or more line reduction in visual acuity" or "acuity of 20/50 or less with spectacles."

Vision Services Approval/Order form (DCH-0893)

Ophthalmologists and optometrists must use the DCH-0893 for hardware orders and prior approval requests.

If an ophthalmologist wishes to obtain the ordered hardware and dispense the items to Medicaid beneficiaries, he/she must also enroll with the MDCH as an optical company.

When a provider fills out a Vision Services Approval/Order form (DCH-0893) to request prior approval or as an order for hardware, the Current Procedural Terminology (CPT)/ Health Care Financing Administration Common Procedure Coding System (HCPCS) coding/modifier structure must be used as well as the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis coding (to the highest specificity).

When requesting prior approval, the provider may mail or fax the Vision Services Approval/Order form (DCH-0893) to:

MDCH VISION CONTRACT MANAGER
6th FLOOR CAPITOL COMMONS CENTER
P.O. BOX 30479
LANSING, MI 48909-7979

Fax: (517) 241-7813

ORTHOPTIC SERVICES

The Program covers orthoptic services as detailed in this section.

Evaluations for beneficiaries having manifest strabismus are covered regardless of the beneficiary's age. Prior authorization is not required for evaluations for beneficiaries age 16 and under, if the diagnosis is esotropia, exotropia, heterotropia, or strabismus. For beneficiaries age 16 and under with a diagnosis **other** than the above and for all beneficiaries age 17 or older, **prior authorization is required**.

A strabismus or amblyopia evaluation is covered once every six months. A strabismus or amblyopia evaluation includes, but is not limited to, case history, visual acuities, determination of objective angle of squint (direction, magnitude, and frequency) determination of subjective angle of squint, diplopia fields (affected muscles), assessment of foveal fixation and macular integrity,

assessment of retinal correspondence, assessment of sensory fusion (suppression, steropsis), accommodative status, vergences (convergence excess/ insufficiency, divergence excess/insufficiency), assessment of cosmesis, diagnosis, treatment programming, and prognosis.

When requesting prior authorization, the physician must indicate the **specific diagnosis** and the beneficiary's best corrected visual acuity of each eye. After the request is approved, the physician performs the evaluation. Following the evaluation, the physician must submit a **new** prior authorization request for treatment and/or any necessary aids.

Treatment for **all** eye muscle problems related to orthoptics, **except eye muscle surgery for beneficiaries under age 21**, requires prior authorization.

Aids must be provided by an enrolled dispensing ophthalmologist or optometrist.

The following documentation must accompany the authorization request:

- description of beneficiary's visual status
- magnitude and direction of the subjective and objective angle of strabismus at distance and near fixation,
- laterality of strabismus,
- frequency of strabismus,
- refractive error of each eye,
- visual acuity, each eye, aided,
- correspondency,
- degree of fusion,
- history of strabismus, including duration, any prior treatment (dates and nature), and any surgery (dates and nature),
- other relevant information,
- a **detailed** treatment plan to include identification of the procedures and equipment to be employed, frequency of office visits, home training, aids, and prognosis.

Orthoptic treatment may be authorized for a period **not to exceed** 3 months, including up to 12 visits.

If continued treatment is necessary **beyond** the period that was authorized, a **new** request for prior authorization must be submitted. The following documentation must accompany the request:

- the documentation requirements as listed under the Special Authorization Instructions for Treatment,
- a report of the results of the previous treatment(s),
- the progress of the case, and the indication for further treatment.

WEIGHT REDUCTION

The Program covers treatment of obesity when done for the purpose of controlling life-endangering complications such as hypertension and diabetes. If conservative measures to control weight and manage the complications have failed, other weight reduction efforts may be approved. **The physician must obtain prior authorization for this service.** The Program does **not** cover treatment specifically for obesity or weight reduction and maintenance alone.

Prior Authorization

The request for prior authorization must include the medical history, past and current treatment and results, complications encountered, all weight control methods that have been tried and have failed, and expected benefits or prognosis for the method being requested. If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter his/her life-style following surgical intervention must be included.

If the request is approved, the physician will receive an authorization letter for the service. A copy of the letter must be supplied to any other provider such as a hospital that will be involved in providing care to the beneficiary.

TUBERCULOSIS (TB) TESTING

The Program covers TB testing according to the guidelines of the American Academy of Pediatrics (AAP), which is based on risk. A risk assessment is completed at each visit. Coverage for the TB test includes any return visit to read the results of the TB test.

NOTE: For assistance in determining high risk, providers may contact the Michigan Department of Community Health's Communicable Disease Epidemiology Division at (517) 335-8165, or the AAP.

GENERAL PRACTICE – SPECIAL CONSIDERATIONS

APHERESIS, THERAPEUTIC

Therapeutic apheresis is covered for the following indications:

- Plasma exchange for acquired myasthenia gravis;
- Leukapheresis in the treatment of leukemia;
- Plasmapheresis in the treatment of primary macroglobulinemia (Waldenstrom);
- Treatment of hyperglobulinemias, including (but not limited to) multiple myelomas, cryoglobulinemia and hyper viscosity syndromes;
- Plasmapheresis or plasma exchange as a last resort treatment of thrombotic thrombocytopenic purpura (TTP);
- Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis;
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease;
- Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome;
- Plasma exchange in the treatment of life-threatening forms of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage;
- Treatment of chronic relapsing polyneuropathy for patients with severe or life-threatening symptoms or failed to respond to conventional therapy;
- Apheresis in the treatment of life-threatening scleroderma and polymyositis, when the patient is unresponsive to conventional therapy.
- Apheresis for the treatment of Guillain-Barre Syndrome; and
- Apheresis as a treatment of last resort for life-threatening Systemic Lupus Erythematosous (SLE) when conventional therapy has failed to prevent clinical deterioration.

Coverage is limited to the following settings:

In a hospital setting (either inpatient or outpatient). Non-physician services furnished to hospital patient are as hospital services. When covered services are provided to hospital patients by an outside provider/supplier, the hospital is responsible for paying the provider/supplier for the services.

In a non-hospital setting, such as a physician directed clinic when all of the following conditions are met:

- A physician is present to perform medical services and to respond to medical emergencies at all times during patient care hours,
- Each patient is under the care of a physician, and
- All non-physician services are furnished under the personal supervision of a physician.

When the physician provides direct supervision of the procedure or personally performs any services, professional services are covered as therapeutic apheresis (plasma and/or cell exchange**)**.

CHEMOTHERAPY ADMINISTRATION

The Program covers the services of a physician who administers antineoplastic chemotherapy to beneficiaries with a cancer diagnosis in the office setting and in the beneficiary's home. The chemotherapy drugs administered by the physician are covered separately.

Administration of other drugs for diagnoses other than cancer are covered under therapeutic, diagnostic, or prophylactic injection/infusion services.

Chemotherapy administration by push and by infusion techniques are covered on the same day; however, only one push administration is covered on a single day.

The physician must personally administer the drug or be present when a qualified employee of the physician administers the drug. If chemotherapy is administered without face-to-face contact between the physician and the beneficiary, the services are covered if furnished in the physician's office by a qualified employee under the physician's supervision and the medical record reflects the physician's active participation in and management of the course of treatment.

In the hospital setting, chemotherapy administration is only covered when the physician personally administers the drug.

Refilling and maintenance of an implantable pump or reservoir is covered. Chemotherapy administration by IV push, infusion, or intra-arterial technique is not covered in addition to refilling the implantable pump or reservoir. Flushing of a vascular port prior to chemotherapy is included in the administration and is not covered separately. If a special visit is made to the physician's office just for port flushing, the service is covered under the appropriate E/M code.

Hydration therapy intravenous (IV) infusion is covered as a part of the chemotherapy IV infusion service when administered simultaneously. Hydration therapy is covered separately when administered sequentially or as separate procedures. The distinct procedural service modifier should be reported with the hydration therapy code when performed sequentially.

Supplies necessary to administer chemotherapy in the office setting are included in the overhead expense portion of the administration services and are not covered separately. Refer to the Medicaid practitioner databases for a listing of covered chemotherapy drugs.

HEMODIALYSIS AND PERITONEAL DIALYSIS

The Program covers physician services required to manage the care of beneficiaries with end-stage renal disease (ESRD) who are receiving ongoing dialysis in an outpatient facility or at home.

Most physician services are covered through a monthly capitation payment (MCP) to the managing physician. The MCP covers ESRD related physician services in all settings necessary to manage the beneficiary's dialysis care, except declotting of shunts, dialysis training, and nonrenal-related medical services.

Self-dialysis training services provided by the physician are covered.

HOME HEALTH CARE

The Program covers home health care subject to the requirements in this section.

Home Health services include intermittent nursing care, home health aide services, and physical therapy provided in the beneficiary's home by a Medicaid enrolled Home Health Agency. The service must be reasonable and necessary for the treatment of a specific illness, injury, or disability, and must be consistent with the nature and severity of the beneficiary's condition, particular medical need and accepted standards of medical practice. Limited services to ensure stability of beneficiaries with an established disability or frail condition, or to prevent an illness, injury or disability for women and newborns during the postpartum period are covered.

Home health is intended for beneficiaries whose conditions require intermittent rather than continuous medical/nursing care. In special instances, intensive nursing care in the home may be approved if the Program determines that home care is appropriate and is a cost-effective alternative to institutional care.

Physician Order for Care

The beneficiary's physician must order covered home health services as part of a written plan of care, and must review the plan of care every 60 days for continuing need. A home health agency should not provide home care prior to the date of the physician's order for the care. The agency must maintain a patient plan of treatment form which must be signed and dated by the physician, or a narrative summary of the plan of care which must have the physician's signed and dated order attached. The home health agency is responsible for obtaining necessary authorization from the Medical Services Administration for special or extended care, which may be provided.

Home health services are not to replace the services of a physician and are not covered solely for the lack of transportation or as a convenience to the beneficiary. Home health services may be appropriate when leaving the home is medically contraindicated or special transportation or effort is required.

Medical Supplies and Equipment

Medical supplies, durable medical equipment, orthotic and prosthetic appliances, shoe supplies, and oxygen are covered for beneficiaries receiving services from an enrolled home health agency. The physician (MD, DO, DPM) must prescribe these items. Refer to the home health manual and the medical suppliers manual chapter III for specific information concerning which equipment/supplies are covered for the medical supplier and which are covered for the home health agency.

Personal Care

If beneficiaries are not in need of nursing care or physical therapy, but have a need for non-specialized, unskilled personal care or chore services, home help is available through the Family Independence Agency (FIA) Home Help Program. The local county FIA office should be contacted for information.

HOSPICE SERVICES

The Program covers hospice services which include palliative and supportive services to meet physical, psychological, social, and spiritual needs of terminally ill beneficiaries and their families in the home, adult foster care facility, home for the aged, nursing facility, or an inpatient hospice setting.

To enroll in hospice, the beneficiary must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the referring physician and the hospice medical director must certify the life expectancy.

The physician should refer to the hospice manual chapter III for specific requirements related to the provision of hospice services.

If the physician is not familiar with Medicaid-enrolled hospices in his/her area, hospice names, addresses, and telephone numbers may be obtained from the Provider Inquiry Line at 1-800-292-2550.

IMPLANTABLE INFUSION PUMPS

The Program covers the refill and reprogramming of implantable infusion pumps by the physician in the physician's office. The refill kit and the electronic analysis of the pump are covered as a part of the refill and reprogramming procedure. Injectable drugs used during this procedure are covered separately in the physician's office.

PEDIATRIC MULTICHANNEL RECORDINGS

The multichannel recording is covered when provided in the inpatient or outpatient hospital setting by qualified personnel and interpreted by a physician. Multichannel recordings are not covered in the patient's home.

A pediatric multichannel recording is a continuous and simultaneous recording of at least four channels that may include ECG, thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Other additional recording parameters may be included. A multichannel recording does not have to include an electroencephalogram (EEG). When an EEG is performed in addition to the four or more channels, it is covered separately. Payment for the multichannel recording will be the same regardless of the number of channels, or the length of time required. The use of a video camera is not separately covered.

Frequency

A multichannel recording is covered for a child under age 21. Two multichannel recordings may be covered in one year for the same beneficiary. If more than two are medically justified, the physician must obtain prior authorization from CSHCS. A copy of the PA approval letter must be attached to the claim form to be reimbursed. The physician is responsible for providing a copy of the PA approval letter to the hospital.

A multichannel recording is covered as a professional service to the physician and as a technical service to the hospital. The professional service includes the interpretation with written report, and the scanning and scoring.

EVALUATION AND MANAGEMENT (E/M) SERVICES

The Program covers medically necessary E/M services provided by a physician or other practitioner authorized by the State. Providers should refer to the CPT explanations, coding conventions, and definitions for evaluation and management (E/M) services.

Most E/M services are covered once per day for the same beneficiary. In these cases, only one office or outpatient visit is covered on a single day for the same beneficiary unless the visits were for unrelated reasons and at different times of the day (e.g., office visit for blood pressure medication evaluation, followed 5 hours later by a visit for evaluation of leg pain following an accident).

Coverage of an E/M service includes related activities such as coordination of care, telephone calls, writing prescriptions, completing insurance forms, review and explanation of diagnostic test reports to the beneficiary.

PREVENTIVE MEDICINE SERVICES

One preventive medicine E/M service is covered for all beneficiaries annually. For beneficiaries under the age of 21 years, EPSDT (Early and Periodic Screening, Diagnosis and Treatment) screening services are covered according to the American Academy of Pediatrics periodicity schedule and CMS requirements. Refer to the EPSDT section of the manual for specific information.

A preventive medicine E/M visit and another E/M visit on the same date are covered separately if during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem oriented E/M visit. When this occurs, the office/outpatient E/M procedure code is covered using the modifier for a separately identifiable service and the preventive E/M visit is covered without using a modifier. Refer to CPT guidelines for additional information.

E/M VISITS IN RELATION TO GLOBAL SURGERY PACKAGE

An E/M service that results in the decision for surgery is covered separately when provided by the surgeon on the day before or the day of a procedure with a 90-day global period and the decision for surgery modifier is reported. This same E/M service provided the day before or the day of a procedure with a 0-day or 10-day global period is not covered separately.

An E/M service is not covered separately on the same day as a procedure with any global surgery period unless the beneficiary's condition requires a significant, separately identifiable E/M service that is above and beyond the pre- and post-operative care associated with the procedure or service performed.

If E/M services are performed by the surgeon during the post-operative global surgery period for a reason unrelated to the surgical procedure, report the appropriate modifier with the E/M service. All care provided during the inpatient stay in which the surgery is performed is compensated through the global surgery package and is not covered separately.

CONSULTATIONS

The Program covers consultations rendered by a physician whose opinion or advice is requested by another appropriate practitioner (e.g. physician, nurse midwife, dentist) for the further evaluation and management of the patient. A consultation includes the preparation of a report of findings that is provided to the referring provider for the referring provider's use in the treatment of the beneficiary. A consultant may initiate diagnostic and/or therapeutic services. If the referring provider transfers complete responsibility for treatment either orally or in writing to the consultant

at the time of the request for consultation, the receiving physician's services are covered as normal E/M services rather as a consultation.

If the referring provider transfers the responsibility for the beneficiary's care to the consultant after the consultation is completed, the consultant's service is covered as a consultation. After the consulting physician assumes responsibility for the beneficiary's care, subsequent visits are covered as established patient office visits or subsequent hospital care, depending on the setting.

A consultation is covered if one provider in a group practice requests a consultation from a physician of a different specialty in the same group practice as long as all of the requirements for use of the CPT/HCPCS consultation codes are met. A request for a consultation from the attending provider and the need for consultation must be documented in the beneficiary's medical record. In an inpatient setting, the request may be documented as part of a plan written in the requesting physician's progress notes, an order in the hospital record, or a specific written request for the consultation.

The program covers second opinions for surgery. The second opinion is covered as a consultation as long as all requirements for a consultation are met.

Ancillary services provided to a patient in a nursing facility must be ordered by the attending physician and are not covered as consultations unless a specific request for opinion and advice is documented. Requests for services by another physician are covered as the actual service provided (e.g., nursing facility visit or eye examination).

INITIAL VISITS

The Program covers one new patient visit for a physician or a group practice for the same beneficiary, regardless of the type of new patient visit billed (e.g., office visit, clinic visit, long-term care visit, home visit).

COMPREHENSIVE VISITS

The Program will cover one comprehensive examination in six months by a physician or group practice for the same beneficiary provided the beneficiary's condition requires that level of an examination and history that often. If a comprehensive history and physical examination is provided more often than once in six months, complete documentation of medical necessity, circumstances, and services provided must be submitted with the claim in order to be considered for coverage.

When a physician provides comprehensive initial hospital care or provides a comprehensive consultation, a comprehensive office examination subsequent to discharge is not covered within a six-month period without supporting documentation.

OFFICE VISITS

The Program covers medically necessary services and emergencies in the office, clinic, or other outpatient settings. CMS guidelines for Medicare and CPT/HCPCS coding descriptions and conventions are used for the reporting of these services.

Coverage for visits includes not only the examination but also the related medical history, evaluation, treatment planning, discussion of findings, consultation with the beneficiary or his/her family, review of pathology and radiology reports, breast and rectal examinations, writing prescriptions, and the drawing, packaging, and mailing of specimens to be analyzed by another provider.

Some services (e.g., I.V. fluid administration, catheterization) are covered in addition to the office visit. Office visits for the sole purpose of rendering a specific procedure (e.g., injections, manipulative therapy, physical therapy, surgical procedures) are considered part of that specific procedure and are not covered separately. The clinical records must substantiate the need for a

separate office visit. If an office visit and initial hospital care are provided on the same date, documentation must be provided to justify coverage of the separate services on the same date.

NOTE: When a specialist provides a thorough examination of the systems within the definition of his/her specialty, the examination is considered a comprehensive examination.

Medicaid covers one comprehensive examination every six months when medically indicated. If a comprehensive examination is rendered more often, complete documentation of medical necessity is required on the claim.

The Program does not cover physical examinations for employment (for beneficiaries age 21 and over) or to determine eligibility for welfare benefits (regardless of the beneficiary's age) even if the local office provides the beneficiary with written authorization for such examination. These examinations are payable through the local office of the Michigan Family Independence Agency (FIA).

The Program does **not** pay for missed appointments. The physician may not charge the beneficiary for a missed appointment.

Routine Examinations

- BENEFICIARIES AGE 21 AND OVER: Routine physicals for this age group are covered. Female beneficiaries may receive one yearly physical including a pelvic examination, Pap test, and a breast examination.
- BENEFICIARIES UNDER 21 YEARS OF AGE: Routine physicals for this age group are covered. In addition, well child exams are covered as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services when performed according to the American Academy of Pediatrics' protocols for children under the age of 21. The physician should refer to the EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) section of the manual for further explanation.

OBSERVATION CARE

Medicaid covers physician services for beneficiaries admitted and discharged from observation status in the hospital setting for a stay less than 24 hours. Coverage is based on CPT coding conventions to report observation stays occurring on a single date and observation stays which start on one date and end on the subsequent date. It is expected that the beneficiary would be discharged from the hospital at the end of observation care. The medical record must include the following documentation:

- the length of time of the observation stay;
- the physician was present and personally performed the services;
- the physician wrote the observation admission and/or discharge notes.

For outpatient surgical procedures, the global surgery rules apply. The surgeon is responsible for all post-operative care in the hospital, and observation care is not covered separately.

Observation care for psychiatric reasons must be authorized by the CMHSP. The CMHSP is responsible for coverage of authorized psychiatric observation care services.

EMERGENCY SERVICES

The program covers all medically necessary emergency services. Federal statutes prohibit prior authorization for coverage of emergency services. Emergency services include covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and the services are necessary to evaluate or stabilize an emergency medical condition. All professional services must be identified as either an emergency or not an emergency.

DEFINITION OF EMERGENCY SERVICES

For the fee-for-service population, the Department defines an emergency medical condition using the federal EMTALA (Emergency Medical Treatment and Labor Act) language: "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health and safety of the woman or unborn child.

For health plan enrollees, the provisions of The Balanced Budget Act (BBA) of 1997 apply to coverage of emergency services. The statute required Medicaid contracts with managed care organizations (health plans) to include coverage of emergency services without regard to prior authorization or the emergency provider's contractual relationship with the health plan. It created an obligation to pay for emergency services obtained by Medicaid enrollees and introduced the "prudent layperson standard." The BBA defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part. This requires health plans to base coverage decisions for emergency services on the severity of the symptoms at the time of presentation (not based on the final diagnosis) and cover examinations where the presenting symptoms were of sufficient severity to constitute an emergency medical condition in the judgment of the prudent layperson.

The determination of whether the prudent layperson standard has been met must be based on the presenting signs and symptoms, not the final diagnosis.

Examples of some emergency conditions include:

- severe asthmatic attack
- acute infections such as cellulitis or abscess
- acute urinary retention
- chest pain
- fractures
- hypo/hyperthermia
- lacerations requiring suturing
- loss of consciousness or impaired mentation

- malignant hypertension
- poisonings/overdose
- seizures, trauma, including burns requiring more than first aid
- uncontrolled diabetes
- uncontrolled hemorrhage

The emergency condition must be fully documented in the medical record.

A situation is **not** considered an emergency if one of the following conditions exist:

- the condition is self-limiting (e.g., pharyngitis, minor cuts)
- it is a non-traumatic condition where initiation of treatment can be delayed 12-24 hours without substantial difference in outcome (e.g., uncomplicated urinary tract infection)
- the condition does not require immediate diagnostic procedures such as laboratory testing, x-rays, electrocardiogram, etc.

URGENT CARE SETTINGS

Physician services rendered in urgent care centers or similar settings that are not part of a licensed hospital are covered. Coverage is based on the appropriate office or other outpatient services E/M procedure codes. Coverage for any additional professional services rendered in these settings follows CPT guidelines.

PHYSICIAN EMERGENCY ROOM CASE RATE

Physician services provided in the emergency department (ED) are covered as individual services. Critical care services are covered according to the CPT/HCPCS definitions and coding conventions for critical care. If critical care is required for a beneficiary in the ED, then only the critical care codes are covered. ED evaluation and management (E/M) or visit codes are not covered on the same day as critical care for the same provider.

When a beneficiary is seen in the ED, the appropriate level of ED E/M service is covered unless another E/M service is more appropriate (e.g., observation care, initial inpatient hospital care, or critical care). The ED E/M service which includes the medical screening exam is covered without regard to whether the beneficiary was released or admitted, or whether the medical screening resulted in the medical condition being deemed an emergency or not. The result of the medical screening examination, along with any medically necessary appropriate diagnostic services, will determine if further treatment must be provided. If the attending physician determines that an emergency medical condition does exist, all subsequent medically appropriate services to stabilize the patient must be provided and are covered in addition to the ED E/M service. CPT/HCPCS coding conventions and Program guidelines must be followed.

For fee-for-service Medicaid beneficiaries, any medically necessary and appropriate professional services provided beyond the ED E/M service are covered individually within CPT/HCPCS coding and Program guidelines.

If the beneficiary is enrolled in a Medicaid Health Plan (MHP) and the physician determines that an emergency medical condition does not exist, the plan or member's primary care physician must be contacted for authorization for any further treatment. If the plan does not respond to the request within one hour, then treatment may be provided and the health plan is obligated to pay for necessary treatment services beyond the ED E/M service.

Diagnostic tests required to assist the physician in determining whether an emergency medical condition exists are covered as long as they are medically appropriate. The medical record must support the need for the type and extent of diagnostic services performed based on the

presenting symptoms of the patient. The ED physician's review of x-rays and EKGs performed on the beneficiary are covered as a part of the E/M service. Professional component services are covered only for the physician who prepares a complete, written report of the findings for the medical record. If this is prepared by a specialist in the field, then the ED physician's review of the findings does not meet the conditions for separate coverage of the service.

The ED E/M services of straightforward through moderate medical decision complexity are covered at a single rate. E/M services requiring medical decision making of high complexity are covered at a higher rate. Additional services are covered separately. Annually, when all physician rates are rebased using the most current RVUs (relative value units), historic utilization, and funds appropriated by the Legislature, the emergency department E/M fee screens will be adjusted accordingly.

Counties that administer their own State Medical (indigent care) Program may have different coverage policies for physician emergency department services. Physicians rendering care to these State Medical Program beneficiaries must contact the entity administering the county program for information on their coverage policies and rates.

MATERNITY CARE AND DELIVERY SERVICES

The Program covers maternity care and delivery services. The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. These services are included in the global obstetric care package. The global obstetric package is covered when one physician or physician group practice provides the obstetric care to a beneficiary. The global obstetric package is covered as long as the provider or group has provided 7 or more antepartum visits, the delivery, and the postpartum care. If less than 7 antepartum visits are provided, report the global package with the modifier for reduced services and indicate the number of antepartum visits on the claim.

ANTEPARTUM CARE

Includes the initial and any subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Typically, if a patient enrolls in the first trimester and delivers at term, she will have about 13 antepartum visits. This will vary depending on the actual start of antepartum care and the delivery date. If the total number of antepartum visits exceeds 13 due to a high-risk condition, the additional visits are covered when using the appropriate E/M codes with the diagnosis for the high-risk condition.

DELIVERY

Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, delivery, and all post delivery in-hospital care. All hospital visits within 24 hours of delivery are generally considered part of the global package. If the patient is admitted more than 24 hours before delivery and stays more than 24 hours, then hospital care rendered prior to the day of delivery are covered separately. Medical problems complicating labor and delivery management that require additional resources are also covered separately.

POSTPARTUM

Includes all the visits following a delivery, both in the hospital and in the office. Services provided by physicians within the same group practice are considered as provided by the primary physician responsible for the patient's overall obstetrical care.

OBSTETRICAL PACKAGE VS. COMPONENTS

If the same physician or group practice does not provide all the obstetric care, the Program will cover the portion of the care provided by each provider. Postpartum care is covered separately if provided by a different physician or group than the one providing the delivery services.

Services that are **not** included in the global package include:

- maternal or fetal echography or fetal echography procedures
- fetal biophysical profile
- chorionic villus sampling, any method
- fetal contraction stress test
- fetal nonstress test
- hospital and observation care visits for premature labor (prior to 36 weeks gestation)

HIGH-RISK PREGNANCY

High-risk pregnancies are those with complicating conditions that are life-threatening to either the mother or fetus and, therefore, require more services than those provided in a routine pregnancy. When high-risk pregnancies require more visits than described for routine obstetrical care and more laboratory data than normally required, the additional services are covered in addition to the global obstetric package. If patient visits are required due to conditions unrelated to the pregnancy, they are also covered in addition to the global obstetric package. The Program follows CPT guidelines for reporting high-risk pregnancy services.

MULTIPLE GESTATION

In the case of multiple gestation, the Program will cover the services provided. Payment follows the multiple procedure rules. Be sure to use a diagnosis code representing multiple gestation.

OB ENHANCED PAYMENTS

The Program provides an enhanced payment for each Medicaid delivery performed. This additional reimbursement is added to the fee reimbursed under fee-for-service for the global maternity and delivery procedure codes. The maternity case rate paid to Medicaid Health Plans (MHPs) is also enhanced.

MATERNITY OUTPATIENT MEDICAL SERVICES (MOMS) PROGRAM

Under the MOMS program, pregnant women can enroll and receive pregnancy related care early in the pregnancy.

Targeted Population

Women who are pregnant or recently pregnant (within 60 days following the month the pregnancy ended), who apply for medical coverage for their pregnancy at a Local Health Department (LHD), Federally Qualified Health Center (FQHC), or Family Independence Agency, and meet one or more of the following criteria:

- **Women:** With incomes at or below 185% of the federal poverty level.
- **ESO Beneficiary:** Women who are covered by the Medicaid Emergency Services Only (ESO) program.

NOTE: Frequently, individuals determined eligible for MOMS may subsequently become eligible for Medicaid. MOMS eligibility is terminated on the effective date of full Medicaid coverage. All services available under the MOMS program are covered by Medicaid. (This does not include Medicaid ESO.)

Period of Coverage

Once the woman is enrolled into MOMS, outpatient pregnancy-related services and the provider's professional fee for labor and delivery are covered from the date of conception through 60 days after the pregnancy ends, regardless of the reason (live birth, miscarriage, or stillborn).

Covered Services

Coverage includes the following outpatient pregnancy-related services during the prenatal and postpartum period:

- Prenatal care
- Pharmaceuticals and prescription vitamins
- Laboratory services

- Labor and delivery – covers both professional fees and inpatient hospitalization
- Postpartum care through 60 days after the pregnancy ends
- Radiology and ultrasound
- Maternal Support Services (MSS) until delivery
- Childbirth education
- Outpatient hospital care
- Other pregnancy-related services with prior authorization

Private Insurance

Private insurance coverage, if any exists for pregnancy related care, must be billed first, unless it would cause a breach in confidentiality. MOMS will be the secondary payer of services if private insurance coverage exists. Reimbursement for services is specified in Chapter IV of this manual. This would include following the rules of any private commercial managed care contract.

NOTE: Services to the infant are not covered at any time under this program. The infant's family/primary caregiver is encouraged to apply promptly for Medicaid coverage for the infant.

Policies and procedures are parallel to Medicaid fee-for-service beneficiaries.

Guarantee of Payment Letter

The Program has developed a process whereby providers are assured payment from the Department for services provided to pregnant women. At the time of accepting an application from a pregnant woman, the Local Health Department, Federally Qualified Health Center, and/or Family Independence Agency will make an initial screening to determine if the woman appears to qualify for Medicaid or MOMS. If they determine the woman appears to qualify for either program, they may issue a Guarantee of Payment letter (DCH-1164) to the pregnant woman to enable her to obtain care immediately and not have to wait for her identification card. The Department will honor a claim received from a provider rendering outpatient pregnancy-related service in good faith based on the Guarantee of Payment letter.

MATERNAL SUPPORT SERVICES (MSS) AND INFANT SUPPORT SERVICES (ISS)

Maternal Support Services (MSS) and Infant Support Services (ISS) are preventive health services that are delivered by an agency, which must be certified by the Michigan Department of Community Health. MSS and ISS services include:

- Psychosocial and nutritional assessment;
- Plan of care development;
- Professional intervention services of a multidisciplinary team consisting of a qualified
    - Social worker,
    - Nutritionist,
    - Nurse, and
    - Infant mental health specialist (if available)
- Arranging transportation **as needed** for health, substance abuse treatment, support services, and/or pregnancy-related appointments;
- Referral to community services e.g. mental health, substance abuse;
- Coordination with medical care providers; and

- Childbirth classes or parenting education classes.

Program services consist of social work, nutrition, nursing services (including health education), counseling/social casework, and beneficiary advocacy services.

Infant mental health specialists should be involved with ISS cases, if at all possible and available in the geographic area. If not available, the provider must consider carefully how to provide this service.

Maternal Support Services

MSS referrals are encouraged given the presence of any of the following conditions, which are likely to adversely affect the pregnancy:

- Homeless or dangerous living/home situation;
- Negative or ambivalent feelings about the pregnancy;
- Mother under age 18 **and** has no family support;
- Need for assistance to care for herself and infant;
- Mother with cognitive, emotional or mental impairment;
- Nutrition problem;
- Abuse of alcohol or drugs or smoking;
- Need for transportation to keep medical appointments; and/or
- Need for childbirth education classes.

Only those pregnant women that meet the above risk criteria should be enrolled in MSS. Medicaid eligibility by itself is not a qualifying condition for enrollment in MSS.

Infant Support Services

ISS referrals are encouraged given the presence of any one of the following conditions existing with the mother or infant:

- Abuse of alcohol or drugs (especially use of cocaine), or smoking;
- Mother is under the age of eighteen (18) **and** has no family support;
- Family history of child abuse/neglect;
- Failure to thrive;
- Low birth weight (less than 2500 grams);
- Mother with cognitive, emotional or mental impairment;
- Homeless or dangerous living/home situation; and/or
- Any other condition that may place the infant at risk for death, illness or significant impairment when indicated by a physician.

For additional MSS/ISS program information please refer to the MSS/ISS Chapter III, Explanation of coverage.

VAGINAL BIRTH AFTER CESAREAN

The Program covers vaginal birth after a previous Cesarean section delivery (VBAC).

Physicians are to use the American College of Obstetricians and Gynecologists' (ACOG) guidelines to determine which beneficiaries are suitable candidates for a successful VBAC. There is no Program mandate to perform a VBAC. This decision is made by the beneficiary and her physician after discussion and consideration of the factors that may affect the pregnancy outcome.

All services of the delivering physician during labor and delivery such as fetal monitoring and resuscitation of the infant when necessary are included in the coverage for the VBAC. All postpartum care of the mother in the hospital is also included and is not covered separately.

PHARMACY

The Program covers pharmaceuticals (both selected legend and selected over-the-counter). The provision of experimental/investigational drugs is **not** covered. The physician must order/prescribe all pharmaceuticals, and the order/prescription must be documented in the beneficiary's medical record.

NOTE: The physician should contact the pharmacy contractor with questions concerning Medicaid's coverage of a specific drug as some drugs may not be covered or require authorization.

The physician must indicate his/her Medicaid provider ID Number on all prescriptions. The pharmacy is required to supply this information when billing the Program.

PRESCRIBED QUANTITIES

Prescribed quantities must be limited to an amount necessary to keep the beneficiary supplied during the therapeutic regimen. In certain cases and conditions, more than a month's supply can be ordered, while for other conditions more frequent monitoring is required. In no instance may the physician prescribe a drug for more than a **120-day supply.**

REFILLS

Refills for a prescription are limited, as follows:

- Schedule II drugs require a new prescription each time, no refills are allowed.
- Dietary formulas, family planning supplies, medical/surgical supplies, and reagents must be refilled according to the physician's instructions.
- Oxygen - the physician must refer to the OXYGEN heading in this Chapter.
- All other legend and nonlegend drugs are allowed up to five refills within 180 days after the original prescription dispensing date. A new prescription is required after 180 days.

METHADONE (NON-SUBSTANCE ABUSE)

Methadone may be dispensed by a pharmacy **only** in cases of severe intractable pain. The beneficiary's record must document the need for methadone and the physician's order. The physician must indicate "Severe Intractable Pain" on the prescription.

CO-PAYMENTS

- **Beneficiaries under the age of 21** or beneficiaries of any age in a **long-term-care facility** are **not** required to make a co-payment.
- **Most beneficiaries age 21 and older** are required to pay a $1.00 co-payment for each prescription for drugs dispensed by a pharmacy with the exception of:
    - family planning drugs and supplies,
    - over-the-counter drugs,
    - pregnancy related drugs,
    - and certain multiple-source drugs with Maximum Allowable Cost (MAC) limits.

The pharmacy has a list of these drugs.

NOTE: If the physician writes a prescription for one of the co-payment drugs and indicates in his/her own handwriting "Dispense as Written" or "DAW," the beneficiary is still required to make a co-payment.

DIETARY FORMULA (ENTERAL FORMULAS)

Enteral formulas require prior authorization. Refer to the Medical Supplier manual chapter III for specific coverages and requirements.

MAXIMUM ALLOWABLE COST (MAC) DRUG

Medicaid has established a maximum allowable cost (MAC) program, which places a ceiling on reimbursement for multiple source drug entities. MAC prices are set for previously patented brand name drugs that are commonly interchanged with lower cost branded and unbranded equivalent products. The "maximum allowable cost" reimbursement is set at the lowest price that a quality product is widely and consistently available. The federal government stipulates certain MAC prices that state agencies cannot exceed.

For some beneficiaries, a physician may find it medically necessary to specify a certain brand name drug. If a physician indicates in his/her own handwriting, "Dispense as Written" or "DAW" on a prescription, this certifies that the specific brand is medically necessary for the beneficiary and the pharmacy cannot substitute the generic equivalent or MAC drug.

NOTE: A copayment is not required for a MAC drug.

NONLEGEND OR OVER-THE-COUNTER (OTCS) DRUGS AND MEDICAL SUPPLY ITEMS

OTCs and medical supplies must be prescribed for coverage. There is no beneficiary co-payment on these products. Only cost effective OTCs are covered.

Certain OTCs are covered for only end-stage-renal disease or for Children's Special Health Care Services (CSHCS) beneficiaries or are covered as part of the per diem rate paid for long term care facilities. Physicians should contact the pharmacy contractor with questions concerning coverage of a specific product.

DRUG UTILIZATION REVIEW PROGRAM (DUR)

The DUR is a statewide therapeutic drug utilization review program that is in place for Medicaid beneficiaries. The drug utilization review committee is comprised of physicians (M.D. and D.O.) and pharmacists. The purpose of the DUR is to:

- To identify high risk cases for drug-induced illness
- To communicate risk factors to prescribers and dispensing pharmacists for evaluation
- To improve beneficiary healthcare outcomes and quality of care

The DUR alerts providers to a beneficiary's medical condition and total drug usage from all prescribers and pharmacies.

Providers should refer to the pharmacy manual, chapter III for detailed information on the Drug Utilization Review Program.

RADIOLOGY, RADIATION THERAPY, AND NUCLEAR MEDICINE

RADIOLOGY SERVICES

Medically necessary radiological services are covered when ordered by a physician to diagnose or treat a specific condition based on the beneficiary's signs, symptoms, and past history as documented in the medical record. Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, and other imaging procedures. Medical need for all services must be documented in the medical record and are subject to post-payment review.

Global/Component Services

The Program covers global physician services in non-hospital settings or the professional component only in any setting. The technical component is only covered when provided and billed by a hospital.

When a physician reports a global procedure, the physician is responsible for the overall performance and quality of the test. The physician must either personally perform the test or it must be performed under the physician's supervision and direction. The physician must personally interpret the results and complete the written report. While some radiology procedures and diagnostic tests may not require the presence of the supervising physician on the premises, other procedures dictate that the physician be present and may even need to be directly involved in the performance of the procedure.

Interpretation of radiology services are covered for any physician trained in the interpretation of the study. The provider who interprets the study must be the one who evaluates the study and prepares and signs the written report for the medical record. Review of results and explanation to the patient is part of the attending physician's E/M service and is not cosidered as interpretation of the study.

Multiple Services on Same Day

The Program covers bilateral x-rays when medically necessary. Bilateral services are studies done on the same body area, once on the right side and once on the left side. Comparison films obtained for routine purposes are not covered. Providers should use a "bilateral" code when available. The Medicaid Practitioner Database indicates all diagnostic procedures that are covered as "bilateral" services. The Program also covers multiple studies of both areas if reported with the appropriate modifier. Examples would include bilateral wrist studies done before and after fracture care on both wrists the same day for the same patient or doing films to assess a patient's response to medical care, such as multiple chest films to monitor the cardiopulmonary status of a critically ill patient.

Studies of contiguous areas, such as the wrist and hand, lumbosacral spine and pelvis, ankle and foot, are covered on the same day when medically necessary to visualize each space. The medical record must support the need for individual studies. If cervical, lumbosacral and thoracic views are performed, an entire spine study should be reported.

Screening mammography is covered according to the American Cancer Society guidelines. Women age 40 and older should have annual breast cancer screening consisting of a clinical breast examination and a mammogram.

Transrectal or prostate ultrasound is covered when the patient is considered at high risk for prostate cancer. It is also covered for pathologic indications that include evaluation of prostatic nodule(s) or abnormalities of the seminal vesicles, staging of prostatic cancer, and monitoring of response to therapy for prostatic cancer.

For CT, MRI and PET scans to be covered, all conditions of CON (Certificate of Need) must be met. These services are subject to standards for provision of the service that include specific staff and designation of who is qualified to interpret the results.

Flat films and CT or MRI studies of the same area are covered on the same day when medically indicated. The provider is responsible for using the most appropriate diagnostic test(s) according to current standards of practice. A CT and a myleogram may be covered on the same day; however, an MRI and a myleogram are covered separately if done on the same day. Coverage of a CT of the spine is limited to one level per day and coverage of an MRI is limited to two levels of the spine on the same day. Providers should be directing the study at the area of the suspected problem.

CT and MRI scans may be done with or without contrast media or both. When a scan is done without contrast followed by another with contrast, only the full service is covered. The global RVUs for CT and MRI contrast scans include allowance for high osmolar contrast media, and the RVUs for global MRIs include allowance for paramagnetic contrast media.

In certain instances, the use of low osmolar contrast media (LOCM) will be separately covered. In the case of intra-arterial and intravenous radiological procedures, LOCM is covered separately for non-hospital patients with one or more of the following:

- a history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- a history or asthma or allergy;
- significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- generalized severe debilitation; or
- sickle cell disease.

If the patient does not meet any of these criteria, the contrast media is considered bundled into the global service and is not covered separately.

When high dose contrast technique is used with MRI, the global service is covered for the procedure designated without contrast, then with contrast. The third MRI (again with contrast) is not separately covered. No additional exists for the contrast material used in the second MRI procedure; however, the contrast material for the third MRI procedure is covered separately.

Obstetrical ultrasound studies are covered in addition to the global obstetrical package. More than two studies are covered only for high-risk conditions such as bleeding, placental abnormalities, fetal post-maturity, etc. The need for the additional studies, including the change in clinical symptoms, must be documented. Pelvic ultrasounds are not covered to diagnose pregnancy or vaginal infections. The use of ultrasound studies for routine fetal age determination in or preparatory for pregnancy termination procedures is considered part of the termination procedure and is not covered separately.

RADIATION THERAPY

The Program covers medically necessary radiation therapy services provided to beneficiaries. CPT/HCPCS guidelines for radiation therapy services are followed.

Following the Medicare guidelines, many services are bundled into the treatment management codes and are not covered separately when the diagnosis is related to the weekly treatment diagnosis and the services are provided by the radiation oncologists or in conjunction with the therapy. The following services are included in the weekly treatment management service:

- anesthesia
- care of infected skin
- checking treatment charts
- continuing-care patient evaluation and examination
- final medical examination
- nutritional counseling
- pain management
- medical prescription
- review and revision of the treatment plan
- routine medical management of related problems
- special care of ostomy
- verification of dosage
- written reports, progress notes
- follow-up examination and care 90 days after the last treatment

Services furnished by a radiation physicist are only covered separately by the Program when provided to a non-hospital beneficiary in a freestanding facility.

Professional services provided to hospital patients are covered only when personally performed by a physician.

Global physician services are only covered if provided in a freestanding, non-hospital setting.

NUCLEAR MEDICINE

The Program covers medically necessary nuclear medicine procedures. Providers are responsible for complying with Nuclear Regulatory Commission (NRC) requirements as necessary. Only professional services rendered to hospital patients are covered for the practitioner.

The Program covers the global services when provided in a freestanding, non-hospital setting. Radionuclides used in the procedures are covered separately.

When specific nuclear medicine diagnostic procedures are performed, the multiple procedure coverage rules apply. The generation and interpretation of automated data is covered as a part of the primary procedure.

HOSPITAL INPATIENT PHYSICIAN SERVICES

The Program covers physician services to hospital inpatients that are medically necessary and follow the requirements in this section. The Program does not cover physician services related to inappropriate or unnecessary inpatient admissions. This includes elective admissions and readmissions, all transfers which are not authorized through the PACE system, and admissions or readmissions which have been inappropriately identified as emergent. This also includes selected ambulatory surgeries inappropriately performed on an inpatient basis or any other inpatient admission determined not to have been medically necessary.

If the Program does not cover the services of the physician or hospital, the physician or hospital must **not** bill the beneficiary, a member or the beneficiary's family, or other beneficiary representative.

ADMISSION

All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition. Elective admissions, readmissions, and transfers for surgical and medical inpatient hospital services must be authorized through the Admissions and Certification Review Contractor (ACRC). The physician should refer to the PACER heading in this section for specific requirements.

Medicaid does **not** cover inpatient hospital admissions for the sole purpose of:

- cosmetic surgery (unless prior authorized),
- custodial or protective care of abused children,
- diagnostic procedures which can be performed on an outpatient basis,
- laboratory work, electrocardiograms, electroencephalograms, diagnostic x-rays,
- observation,
- occupational therapy,
- patient education,
- physical therapy,
- routine dental care,
- routine physical examinations not related to a specific illness, symptom, complaint, or injury,
- speech pathology, or
- weight reduction, weight control (unless prior authorized).

Any accommodation or ancillary services provided during nonallowable admissions or parts of stays are **not** covered. The physician may **not** bill the beneficiary for any surgical/medical charges since the admission was unnecessary.

PRIOR AUTHORIZATION AND CERTIFICATION EVALUATION REVIEW (PACER)

Elective admissions, all readmissions within 15 days, and all transfers for surgical or medical inpatient hospital services to and from any hospital enrolled in the Medicaid program requires authorization through the ACRC. This includes transfers between a medical/surgical unit and an enrolled distinct part rehabilitation unit of the same hospital. All cases are screened using the

severity of illness/intensity of services (SIIS) criteria sets approved by the Program, and the clinical judgement of the review coordinator. An ACRC physician will make all adverse decisions.

If an admission, readmission, transfer, or continued stay is not approved, Medicaid will not cover the hospital or physician services rendered.

The ACRC completes the admission, readmission, or transfer review through the PACER system and assigns a PACER number.

The attending/admitting physician or representative is responsible for obtaining the PACER number **before** admitting, readmitting, or transferring the beneficiary with exceptions as noted below.

The telephone number to obtain PACER authorization is: 1-800-727-7223.

Physicians will be asked to provide the procedure code when a surgical admission/readmission is requested. If the ACRC does not authorize the admission/readmission/transfer, the physician can request a reconsideration. This request must be made within three working days of the denial.

NOTE: Authorization for the hospital admission does not remove the need for prior authorization for specific services. Any prior authorization required for the service must be obtained before the ACRC authorization is requested.

EXCEPTIONS: The following do not require a PACER number:

- Emergent admissions, (hospital services billed as emergent will be reviewed on a post payment sample basis).
- Transfers to distinct-part psychiatric units or freestanding psychiatric hospitals (authorization must be requested through the local Community Mental Health Services Program).
- Obstetrical beneficiaries admitted for any delivery.
- Newborns admitted following a delivery. Exception: all transfers of newborns following delivery require a PACER number. The initial and subsequent transfers of the newborn must be authorized by the ACRC.
- Children's Special Health Care Services (CSHCS) beneficiaries. Authorization is required if the admission is not related to the qualifying CSHCS diagnosis.
- Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP).
- CSHCS beneficiaries enrolled in a Special Health Plan (SHP).
- When a beneficiary is admitted to a hospital not enrolled with the Michigan Medicaid Program.
- When a beneficiary becomes Medicaid eligible after the admission, readmission, transfer, or certification review period.

The physician is responsible for providing the PACER number to the admitting hospital. If an urgent or emergent readmission to the same hospital as the original admission occurs, the PACER number for the readmission must be made by the next working day following the readmission.

Providers are referred to the Hospital Manual chapter III for additional information concerning the ACRC and PACER processes.

VENTILATION MANAGEMENT

Ventilation management provided in the inpatient hospital setting is covered separately unless an E/M service is provided on the same day.

CRITICAL CARE

The Program covers critical care consistent with the CPT/HCPCS definitions and guidelines. Each day that critical care is provided, the medical record must support the level of service provided

The actual time spent with the patient delivering critical care services must be documented in the medical record.

RESPIRATORY CARE

The Program covers respiratory care as a separate service in the inpatient hospital setting for the anesthesiologist/physician who initiates respiratory care by setting up the respirator, placing the beneficiary on the respirator, and providing daily supervision of the beneficiary for the respiratory care alone.

STANDBY SERVICES

The Program does not cover the services of a standby surgeon, anesthesiologist or surgical team. Only direct beneficiary care is covered. Physician standby services are covered as a part of the hospital services.

SURGERY - GENERAL

The Program covers medically necessary surgical procedures.

GLOBAL SURGERY

Coverage for global surgery package includes related services that are furnished by the physician who performs the surgery or by members of the same group with the same specialty. Medicaid policy is based on CMS guidelines for Medicare services for the global surgery package.

The global periods are identified on the Medicaid Physician Database. The payment rules for global surgery apply to global periods of 000 (only services on the day of the procedure are included), 010 (10 day global period), 090 (90 day global period), and YYY (global period determined on case-by-case basis). Codes with 000 and 010 global periods include endoscopies and minor procedures. Codes with a 090 global period include major surgeries. Codes with a YYY are individually priced and the Program determines the global period.

Services Included in the Global Surgery Package:

- Pre-operative visits beginning with the day before the surgery for major surgeries and the day of the surgery for minor surgeries
- Intra-operative services that are a usual and necessary part of a surgical procedure
- Complications following surgery. This includes all additional medical or surgical services required of the surgeon during the post-operative period due to complications that do not require return to the operating room. The surgeon's visits to a patient in an intensive care or critical care unit are also included.
- Follow-up visits within the post-operative period related to recovery from the surgery
- Post-surgical pain management by the surgeon
- Supplies for certain services furnished in a physician's office
- Miscellaneous services and items such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.

Services Not Included in the Global Surgery Package:

- The surgeon's initial consultation or evaluation of the problem to determine the need for surgery
- The office or hospital visit to decide upon surgery, if it occurs on the day before or the day of a major surgery.
- Other physicians' services, except when the surgeon and the other physician(s) agree on the transfer of care (The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital records, or ASC records).
- Visits unrelated to the diagnosis for which the surgical procedure was performed.
- Treatment of the underlying condition or an added course of treatment that is not part of the normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiology procedures.

- Clearly distinct surgical procedures that are not re-operations or treatment for complications during the post-operative period. A new post-operative period begins with the subsequent procedure.
- Staged procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples include procedures to diagnose and treat epilepsy in succession within 90 days of each other.
- Laser eye surgeries (and all other services whose CPT/HCPCS description includes one or more sessions) performed in a series over a period of weeks or months are not considered staged procedures. All sessions during the post-operative period of the first session are covered as a part of the global package.
- Chemotherapy and/or radiation therapy following cancer surgery.
- Treatment for post-operative complications that requires a return to the operating room. For this purpose, an operating room is a place of service specially equipped and staffed for the sole purpose of performing surgical procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. Not included is a patient's room, a minor treatment room, a recovery room, or intensive care unit unless the patient's condition is so critical there is insufficient time for transportation to an operating room.
- A second, more extensive procedure when a less extensive procedure fails.
- A therapeutic service that is required during the post-operative period of a diagnostic service. Example: A D&C followed by a therapeutic hysterectomy performed during the D&C's global period.
- Immunosuppressive therapy for organ transplants.
- Critical care services unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
- Visits that are a significant, separately identifiable service on the same day as a minor surgery or endoscopy. For example, a visit for a full evaluation of a lump in the breast on the same day as a removal of a lesion on the back.

When a beneficiary is returned to the operating room for treatment of complications, only the intra-operative portion of the service is covered.

LESS THAN THE FULL GLOBAL PACKAGE

Services of physicians furnishing less than the full global surgery package are covered. Modifiers are used to identify the portion of the global surgery package that is covered separately when performed by different physicians under certain circumstances. Only procedures with 10- or 90-day global periods are eligible for partial global surgery package coverage.

The surgeon should use the modifier for surgical care only when another physician provides all or part of the outpatient post-operative care. The Program assumes that the surgeon is responsible for pre-operative, intra-operative and inpatient hospital post-operative care at a minimum.

The modifier for post operative management only is used when a second physician provides all or part of the post-operative care after hospital discharge in the global package. The surgeon must transfer care to the second physician, and both must keep a copy of the written transfer agreement in the beneficiary's medical record.

BILATERAL SURGERY

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The descriptions for some procedure codes include the terms "bilateral" or "unilateral or bilateral." The RVUs for these codes reflect the work involved if done bilaterally as the description states. Other procedure code descriptions do not include "bilateral" but may be performed bilaterally. The bilateral procedure modifier is used with these procedure codes.

The Medicaid Practitioner Database includes an indicator for those procedures that the bilateral procedure modifier can be used with. Reimbursement for a bilateral procedure reported appropriately with this modifier is based on the lower of the amount billed or 150% of the fee screen for the procedure.

MULTIPLE SURGICAL PROCEDURES

Multiple surgeries are separate procedures performed by a physician on the same beneficiary during the same operative session or on the same day for which separate coverage may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same beneficiary on the same day.

When the same physician performs multiple surgical procedures during one operative session, all services are covered separately. The Program follows CMS multiple surgery guidelines for coverage of the procedures. If an integral procedure (one that is part of a larger surgery and is necessary to perform the larger surgery) is performed, it is covered as a part of the larger procedure. If two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases), the procedures are covered separately.

Multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician, or physicians of the same specialty in the same group practice. Medicaid will reimburse up to 100% of the fee screen for the most complex surgical procedure and up to 50% of the fee screens for the second through the fifth surgical procedure. If more than five multiple procedures are performed, an operative report must be provided with the claim.

MULTIPLE ENDOSCOPY PROCEDURES

Multiple endoscopy procedures will be reimbursed based on the full fee for the highest paid service plus the difference between the next highest and the base endoscopy. When related endoscopies are performed on the same day as other endoscopies or other surgical procedures, the standard multiple surgery rules apply. The multiple surgery rules consider the coverage for the related endoscopies as one service and any other unrelated endoscopy or procedure as another service.

MULTIPLE SURGEONS

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same beneficiary during the same operative session. This may be required due to the complex nature of the procedures or the beneficiary's condition. The Medicaid Practitioner Database includes multiple surgeon indicators on allowable procedures.

CO-SURGEONS

Two surgeons who work together as primary surgeons performing distinct parts of a total service are considered co-surgeons. The medical record must contain sufficient documentation supporting the medical necessity for co-surgeons. Report the modifier indicating two surgeons for the services furnished by each co-surgeon. The primary procedure will be reimbursed at the full screen times 62.5%. Second and subsequent services will be paid at 50% of the full-allowed amount times 62.5%.

TEAM SURGEONS

Three or more surgeons who work together as primary surgeons to perform a specific procedure are considered team surgeons. Sufficient documentation must be submitted with the claim to establish that a team was medically necessary. If two or more surgeons are of the same specialty, the reason each was needed must be documented also. Report the surgical team modifier when billing for services rendered by each team surgeon. Each surgeon's dictated operative report must be included with the claims. Reimbursement will be based on individual consideration.

ASSISTANT AT SURGERY/ ASSISTANT SURGEON

Medicaid covers assistant at surgery services for designated surgical procedures. Assistant at surgery services must be considered reasonable and necessary for the surgery performed. An assistant at surgery actively assists the primary surgeon during the surgical procedure. Coverage for assistant at surgery services will not be allowed when co-surgeons or team surgeons are utilized.

Medicaid does not cover assistant surgeon services in a teaching hospital setting unless a qualified resident is not available. The medical record must document the circumstances causing the unavailability of a qualified resident. The surgical procedure is reported with appropriate modifier identifying use of an assistant surgeon.

The Program covers assistant at surgery services performed by a second physician, a physician's assistant (PA), or a nurse practitioner (NP). PA and NP services as assistant at surgery must be under the delegation and supervision of the physician employing the PA or NP or a physician employed by the same group practice that employs the PA or NP. If the PA or NP are employees of the hospital, their services are covered as a part of the hospital charges.

SURGEONS PERFORMING DISTINCTLY DIFFERENT UNRELATED PROCEDURES

If two or more physicians each perform distinctly different, unrelated surgeries on the beneficiary on the same day, the payment adjustment rules for multiple surgeries or co-surgeons do not apply. In such cases, the multiple procedures modifier should not be used unless one of the surgeons individually performs multiple surgeries.

DESTRUCTION OF LESIONS

Destruction of lesions by methods such as electrocautery, cryocautery, laser, and surgery are covered by the Program.

Coverage of the surgical destruction of lesions which involve more extensive procedures are limited to the hospital setting. Less extensive procedures are covered in the office setting. Refer to the practitioner database to determine which procedures require a hospital setting for coverage and which procedures are covered in the office setting. If retreatment to the same lesion is necessary, it is covered as an office visit.

Chemocautery or chemical destruction of any lesion, such as the use of a nitrate stick or podophyllin, is covered as a part of the office visit.

VISION PROCEDURES AND CARE

Ophthalmologists may transfer post-operative care associated with cataract removal or insertion of an intraocular lens prosthesis to an optometrist. In this case, the ophthalmologist who performs eye surgery but does not provide the post-surgical care must report the surgical care only modifier with the surgery procedure code. This includes the pre-operative care, the surgery, and any in-hospital post-operative care. Post-operative care after hospital discharge is covered separately for the provider that the care was transferred to using the surgery code with the post operative management only modifier.

Surgical procedure descriptions that include the phrase "one or more sessions" includes all sessions. These procedures include the 90-day global period during which the procedure(s) can be completed in one or more session(s). These procedures include trabeculoplasty by laser surgery, iridotomy/iridectomy by laser or photocoagulation, repair of retinal detachment, destruction of retinal or choroid lesions. The code description in CPT identifies when one or more session is included. Separate coverage for a second or subsequent session of the same procedure during the global period of the initial service is limited to cases where the modifier reported with the procedure code indicates that services were performed on different eyes.

SURGERY – SPECIAL CONSIDERATIONS

ABORTIONS

As required by Act No. 124 of the Public Acts of 1996, which became effective April 1, 1997 any separating or unbundling of services directly related to the performance of an abortion for the purposes of seeking Medicaid reimbursement is an inappropriate use of taxpayer funds. The law defines an abortion, and the health care professionals, facilities, and agencies affected by this law. It also imposes a civil fine of up to $10,000 if a health care professional or a health facility or agency seeks or accepts reimbursement for the performance of an abortion knowing that public funds have or will be used in whole or in part for the reimbursement of the procedure or related services.

Medicaid will only cover an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met.

The physician certifies on a completed Certification for Induced Abortion Form, MSA-4240 (Rev. 5-97) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the MSA-1550 and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

A copy of Form MSA-4240, Certification for Induced Abortion, completed by the physician and a Beneficiary Verification of Coverage Form MSA-1550 must accompany all claims except those for ectopic pregnancies or spontaneous, incomplete or threatened abortions.

The medical record must include a complete beneficiary history including the medical conditions that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and that the pregnancy was the result of rape or incest.

Refer to the forms section of this manual for copies of the MSA-4240 and MSA-1550. The forms are also available of the Department's website at www.michigan.gov/mdch.

COSMETIC SURGERY

The Program only covers cosmetic surgery if prior authorization has been obtained. The physician may request prior authorization if any of the following conditions exist:

- the condition interferes with employment, or
- it causes significant disability or psychological trauma (as documented by psychiatric evaluation), or
- it is a component of a program of reconstructive surgery for congenital deformity or trauma, or
- contributes to a major health problem.

The physician must identify the specific reasons any of the above criteria are met in the prior authorization request.

The physician should refer to the Prior Authorization section of Chapter I for specific information for obtaining authorization.

HYSTERECTOMY

A hysterectomy is covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign a written acknowledgment of receipt of that information. The Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) will serve as the written acknowledgment.

All items on the MSA-2218 must be completed. The form must be signed by the beneficiary (or representative) and the physician (M.D. or D.O.).

Federal regulations prohibit Medicaid coverage for hysterectomies performed solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

Exceptions

The Acknowledgment of Receipt of Hysterectomy Information is not required in the following situations:

1. The beneficiary was already sterile before the hysterectomy.
2. The beneficiary requires a hysterectomy because of a life-threatening emergency situation. It was not possible for the physician to inform the beneficiary in advance that the surgery would make her permanently incapable of reproducing.
3. The hysterectomy (as covered according to Medicaid policy) was performed during a period of retroactive eligibility.

Acknowledgement of Form for Hysterectomy (MSA-2218)

To encourage paperless billing and reduce administrative burden, the MSA allows for submission of the acknowledgement of receipt of hysterectomy information forms via fax. Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. This process can eliminate submitting paper attachments for hysterectomy claims, and will preconfirm the acceptability of the completed acknowledgement form, as well as reduce costly claim rejections.

The provider who obtains the required acknowledgement and completed the MSA-2218 may fax the completed form, along with a cover sheet, to the Payment Processing Division. The form will be reviewed within five working days and either an explanation of errors or notice that the form has been accepted and is on file, will be returned to the submitting provider. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted without attachments.

Procedure for Acknowledgement Form Approval

1. Complete a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.

2. Fax the cover sheet and completed acknowledgement form to: Hysterectomy acknowledgement form approval, fax number 517-241-7856.

3. Wait for a response. When you are notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response.

4. If there is no response within five working days: Confirm that your fax is working. Be sure that your cover sheet included the necessary information for Medicaid staff to contact you. Resend the information if necessary.

You may still continue to attach a copy of the acknowledgement form to your claim without going through this preapproval process. The MSA-2218 form is available on the DCH website.

ORGAN TRANSPLANTS

The Program covers organ transplants and related services if all requirements for these services are met. Prior authorization is required for all beneficiary, donor, and potential donor services related to all organ transplants except cornea and kidney transplants. If transplantation of additional organ(s), is to occur during the same operative session as a cornea or kidney transplant, prior authorization is required.

Prior to surgery, the beneficiary must be evaluated at an accepted transplant center to determine if he/she is a good transplant candidate. The attending physician must obtain the prior authorization for this evaluation. If the beneficiary is accepted as a transplant candidate, the prior authorization for the evaluation will also cover the transplant, and related services.

Authorization Instructions

If Medicare eligibility is denied, the denial notice must be attached to the prior authorization request.

If the Medicare application is still pending, this should be indicated on the prior authorization request. Once a final determination is made, the Program must be notified.

The donor must exhaust all possible insurance sources before Medicaid is billed for the services.

A copy of the letter of authorization for the evaluation for transplant that was sent to the attending physician from the Office of Medical Affairs must be submitted with the claim.

Transportation and Lodging

Transportation and lodging expenses associated with the evaluation and the transplant are covered for the beneficiary and one accompanying individual (e.g., spouse, parent, guardian). The beneficiary's local Family Independence Agency office should be contacted to make travel arrangements if the beneficiary has only Medicaid coverage or they are dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid. If the beneficiary only has CSHCS coverage he/she must contact the CSHCS office in the local health department, of the county where they reside, to make travel arrangements. The mode of transportation should be that deemed medically necessary for the beneficiary by the attending physician.

Donor Searches

Charges for donor searches, which do not result in an organ acquisition and transplant, are covered as an outpatient service by the hospital and not covered for the physician.

STERILIZATION

The Program covers sterilization procedures when specific requirements are met. The Program defines a sterilization procedure as any medical procedure, treatment, or operation for the purpose of rendering an individual (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under the Program's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed consent form (MSA-1959 Informed Consent to Sterilization).

Sterilizations will only be covered if:

- The beneficiary is at least 21 years of age at time of informed consent.
- The beneficiary is not legally declared to be mentally incompetent.
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility.
- Informed consent is obtained.
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.
- Informed consent must be obtained not less than 30 days nor more than 180 days prior to sterilization.

NOTE: The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

- In cases of premature delivery, informed consent must have been given at least 30 days before the expected delivery date. The consent form must indicate the expected date of delivery.
- In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified, e.g., diagnosis, physician's statement, or hospital summary. The nature of the emergency must be included on the consent form.

Informed Consent Process

The following procedures must be included in the process of informed consent:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days after the informed consent to sterilization is signed, except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains informed consent must offer to answer any questions the beneficiary may have concerning the procedure.
- Suitable arrangements must be made to ensure that information is effectively communicated to the deaf, blind, or otherwise handicapped.
- An interpreter must be provided if the beneficiary does not understand the language used on the informed consent form or the language used by the person obtaining informed consent.
- The beneficiary is permitted to have a witness of his choice present when informed consent is obtained.
- At the time of the informed consent, a copy of the consent form must be given to the beneficiary.

All of the following sterilization information and advice must be presented orally to the beneficiary both at the time the beneficiary signs the informed consent form and again by the physician performing the sterilization shortly before the procedure (e.g., during the preoperative examination):

- advice that the beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled,
- a description of available alternative methods of family planning and birth control,
- advice that the sterilization procedure is considered to be irreversible,
- a thorough explanation of the specific sterilization procedure to be performed,
- a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used, and
- a full description of the benefits or advantages that may be expected as a result of the sterilization.

The beneficiary, the person who obtained the consent, and the interpreter (if required) must sign the informed consent form at least 30 days but not more than 180 days prior to the sterilization. The physician performing the sterilization must also sign and date the informed consent form after the sterilization has been performed.

No additional reimbursement is allowed for the examination or the sterilization explanation.

If the procedure will occur in a place other than that in which the consent form is signed, e.g., forms were signed in the physician's office, but the procedure will be rendered in the hospital, the person obtaining consent must send a copy of the completed form to the place of surgery. The second provider (e.g., hospital) will be responsible for acquiring the physician's statement (if not previously documented) and for photocopying the signed form and supplying copies to any other Medicaid provider who will be billing as a participant in the sterilization.

A copy of the completed Informed Consent to Sterilization (MSA-1959) is required for coverage of charges related to a sterilization procedure. This form may be faxed or attached to the claim form.

Consent Form for Sterilization

To encourage paperless billing and reduce administrative burden, the Program allows for submission of Informed Consent to Sterilization forms via fax. Federal regulations require that this form be submitted to the Program before reimbursement can be made for any sterilization procedure. This process can eliminate submitting paper attachments for sterilization claims, and will preconfirm the acceptability of the completed consent form.

The provider who obtains the required consent and completed the MSA-1959 may fax the completed consent form along with a cover sheet to the Payment Processing Division at the fax number noted below. The form will be reviewed within five working days, either an explanation of errors or notice that the form has been accepted and is on file, will be returned to the submitting provider. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted to the Program without paper attachments.

Procedure for Consent Form Approval

- Complete a cover sheet (typed or printed) which must include: Beneficiary name, Beneficiary Medicaid ID number, Provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed consent form to: Payment Procesing Division, Sterilization Consent Form Approval, fax number (517) 241-7856. DO NOT FAX INVOICES.
- Wait for a response. When you are notified that the consent form has been accepted and is on file, inform the other providers via a copy of the response.
- You and other providers may then submit claims (either paperless or hard copy) to Medicaid. The "Remarks section" or "Comment Record" must include the statement "Consent on File."
- When sterilization claims are received with this information in the remarks, consent form edit requirements will be forced if the submitted invoice matches the consent form on file.
- If there is no response within five working days: Confirm that your fax is working. Be sure that your cover sheet included the necessary information for Medicaid staff to contact you. Resend the information if necessary.

This process is an option. You may attach a copy of the consent form to your claim without going through this preapproval process. The MSA-1959 form is available on the DCH website.

Reversal of Sterilization

Services to reverse a previous sterilization are not covered by the Program.

DURABLE MEDICAL EQUIPMENT/ORTHOTICS/PROSTHETICS

The Program covers medically necessary durable medical equipment (DME), orthotics, and prosthetics that are provided through an enrolled Medicaid provider (i.e. medical supplier or orthotist/prosthetist). The coverage of items for beneficiaries under the age of 21 may differ from those beneficiaries 21 years of age and older. In addition, items for beneficiaries under 21 years of age may be covered the by Children's Special Health Care Services (CSHCS) program.

Determination of the medical necessity of the equipment/supplies is the responsibility of the physician. A beneficiary's need for medical supplies, equipment, and appliances must be reviewed by a physician annually. In all cases, the ordering physician's name must be on the prescription or Certificate of Medical Necessity (CMN) document.

A prescription for these items must contain the following:

- beneficiary's name
- prescribing physician's name, address, and telephone number
- prescribing physician's signature (a stamped signature will not be accepted)
- the date the prescription was written
- the specific item prescribed
- the amount and length of time that the service is needed.

A new prescription and/or CMN will be required when there is a change in the beneficiary's condition causing a change in the item or the frequency of its use.

For beneficiaries eligible for CSHCS coverage only, these additional requirements apply:

- The prescription must be related to the CSHCS qualifying diagnosis.
- A physician specialist must sign the prescription if customized DME items or prosthetic/orthotic appliances are ordered or for other specific services as noted in section 2 of chapter III of the Medical Supplier's manual.

A CMN must contain the following:

- Beneficiary's name and address
- Prescribing physician's signature, date of signature and telephone number
- The supplier's name and address
- The expected start date of the order (if different from the prescription date)
- A complete description of the item
- The amount and length of time the item is needed
- Beneficiary's diagnosis
- The medical necessity of the item

Refer to the medical suppliers manual chapter III for additional information related to coverage for these items.

ORTHOTICS/PROSTHETICS

The physician must provide the orthotist/prosthetist/supplier with a written prescription and/or medical documentation so the orthotist/supplier can supply the item(s).

SHOES AND SHOE SUPPLIES

The Program covers special kinds of shoe supplies for beneficiaries when provided by a medical supplier, orthotist, or prosthetist. The physician's written prescription and diagnosis needed to submit a request for prior authorization must include the following:

- Diagnosis/medical condition related to the service requested
- Medical reasons for specific shoe type and/or modification
- Functional need of the beneficiary

Orthopedic shoes and inserts are covered if:

- Ordered by a sub-specialist such as a pediatric orthopedic surgeon, neurologist, or physiatrist **AND**
- Required to accommodate a led length discrepancy of ¼ inch or greater or a size discrepancy between both feet of one size or greater **OR**
- Required to accommodate needs related to a partial foot prosthesis, club foot, or plantar fascitis **OR**
- Attached to an orthotic appliance or brace

Shoes and inserts are not covered for the following conditions:

- Pes Planus or Talipes Planus (flat foot)
- Adductus metatarsus
- Calcaneus Valgus

Diabetic Shoes, Inserts, and/or Modifications are covered for individuals who have, due to complications with diabetes mellitus, the following conditions:

- History of previous foot ulcerations or pre-ulcerative calluses
- Peripheral neuropathy or sensory impairment

HOME APNEA MONITORS

The physician must complete a prescription or CMN for the home apnea monitor and provide a copy of this to the medical supplier.

Standards of Coverage

Apnea monitors may be covered for the following:

- **For Newborn Infant Following Hospital Discharge**
  - Apnea of newborn
  - Apnea of prematurity
  - Apparent life threatening event (ALTE)
  - Sibling of Sudden Infant Death Syndrome (SIDS)
  - Bronchopulmonary Dysplasia

- **For Siblings of Sudden Infant Death Syndrome (SIDS) Following Hospital Discharge**

  Units are covered for up to one month past the age of the sibling who died from SIDS **(or)** up to three months past the age of the sibling who died if the child was a twin of the beneficiary being monitored.

- **Respiratory Illness**

  Short-term coverage of a unit (up to two months) is covered when the beneficiary has a respiratory illness/diagnosis such as Pertussis, Respiratory Syncytial Virus (RSV), or Pneumonia.

- **As a Diagnostic Tool**

  Short-term coverage of a unit (up to three months) used as a diagnostic tool is covered if the infant is under three months of age and the parent and/or guardian reports events.

- **Ventilator Dependent or Tracheostomy Individuals**

  Units may be covered if after consideration of comprehensive equipment use, medical needs are still not met. Medical justification must be submitted detailing the plan of management.

Non-Covered Conditions

Apnea monitors are **not covered** for the following:

- Beneficiaries over the age of one year
- For diagnoses/conditions as listed unless documentation justifies medical necessity and usage meets the established standards of coverage:

  Chromosomal abnormalities

  Congenital heart defects with or without arrythymias

  Cerebral Palsy

  Asymptomatic prematurity

  Developmental delay/mental retardation

  Seizure disorder

  Hydrocephaly with or without Arnold-Chiari Syndrome

  Irreversible terminal conditions

  Distant family history of SIDS (other than immediate sibling)

- **Situations of non-compliance by family members** with the unit's importance and proper usage.

Additional information is available in the Medical Supplier Chapter III.

HOME UTERINE ACTIVITY MONITORS (HUAM)

The Program may cover the use of a HUAM in the home setting for a beneficiary at high risk for pre-term delivery during the 24th through the 36th week of the gestation period and one of the following medical conditions applies:

- Pre-term labor or tocolytics,
- History of pre-term labor or delivery in previous pregnancies,

- Incompetent cervix (cerclage),
- Multiple gestations.

Refer to the Medical Suppliers chapter III for additional information related to HUAMs.

Prescription/Certificate Of Medical Necessity

The physician must complete a prescription/certificate of medical necessity (CMN) for the use of the HUAM to be kept in the medical supplier's records. The prescription/CMN must include all of the following:

- Diagnosis and/or medical condition
- Gestational age
- Expected date of birth
- Last day of the 36th week of gestation
- Involvement with the regional perinatal center

PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

PSYCHIATRIC SERVICES

The Program covers psychiatric services for diagnostic or active treatment purposes. Psychiatric services are covered by the local CMHSP for services included under the capitation payments to the CMHSPs and a limited outpatient benefit is covered for beneficiaries enrolled in Medicaid Health Plans (MHPs). Services to beneficiaries not included in the capitation payments to the CMHSPs **and** not enrolled in Medicaid managed care plans are covered through the fee-for-service Medicaid program. The fee-for-service program limits outpatient visit coverage to a maximum of ten psychiatric visits in twelve months. **Under the fee-for-service program**, only those psychiatric services personally rendered by a physician (M.D. or D.O.) are covered. Those services performed by other staff personnel (e.g., psychologists, social workers, NPs, PAs) are not covered. Refer to the physician database for specific services which are covered.

Services provided to beneficiaries enrolled in Medicaid Health Plans (MHPs) must be authorized by the individual MHP.

Refer to the CMH and Substance Abuse Medicaid manual chapter III for services covered by the CMHSPs and authorization requirements.

Psychological Testing

The Program covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's mental or developmental status and strengths and needs. If a beneficiary requires psychological testing more than once per year, documentation of medical necessity must be maintained in the medical record. Psychological testing must be ordered by a physician (M.D. or D.O.) and must be performed by a psychologist who is fully-licensed, limited-licensed, or temporary-limited-licensed. This order must be kept in the beneficiary's clinical record. Supervision of limited-licensed and temporary limited-licensed psychologists must comply with the requirements of PA 368 of 1978, as amended.

Psychological testing under the fee-for-service program is only covered under the physician's provider identification number. The physician's provider identification number reported for coverage must be the ordering physician, the physician employing the psychologist, or a physician employed by the group which also employs the psychologist. The physician ordering psychological testing must examine the beneficiary. The physician employing the psychologist or employed by the same group that employs the psychologist does not need to examine the beneficiary in order to bill for the psychological testing unless that physician orders the psychological testing.

Inpatient Psychiatric Admissions

Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Inpatient treatment, including related psychiatric visits, in a free-standing psychiatric hospital, both private and state owned, is limited to eligible **beneficiaries under age 21, and age 65 and older.** If the beneficiary was an inpatient immediately prior to attaining age 21, he/she would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following his/her 21st birthday, coverage terminates on the discharge date.

All psychiatric admissions and continued stays must be authorized by the local CMHSP. Refer to the CMH and Substance Abuse Medicaid manual chapter III for specific coverages and authorization requirements.

Psychiatric Partial Hospitalization

Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist.

All partial hospitalization admissions and continued stays must be authorized by the local CMHSP. Refer to the CMH and Substance Abuse Medicaid manual chapter III for specific coverages and authorization requirements.

SUBSTANCE ABUSE SERVICES

The Program covers acute care detoxification in the inpatient hospital for fee-for-service beneficiaries and through the Medicaid Health Plans (MHPs) for beneficiaries enrolled in Medicaid Managed Care.

Acute Care Detoxification

Admission to the acute care setting, for a diagnosis of substance abuse must meet at least one of the following criteria. Physician's orders and patient care plans must reflect the appropriate criteria:

- Vital signs, extreme and unstable. Uncontrolled hypertension, extreme and unstable.
- Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment.
- Convulsions or multiple convulsions within the last 72 hours.
- Unconsciousness.
- Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus.
- Insulin dependent diabetes complicated by diabetic ketoacidosis.
- Suspected diagnosis of closed head injury based on trauma injury.
- Congestive heart disease or ischemic heart disease or significant arrhythmia as examples of active symptomatic heart disease.
- Suicidal ideation and gestures necessitating suicidal precautions as part of treatment.
- Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse.
- Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence.
- Active presentation of psychotic symptoms reflecting an urgent condition.

Other Substance Abuse Services

The Program covers other substance abuse services provided to beneficiaries. These services are covered under capitation payments to the CMHSPs. Providers must refer to the CMH and Substance Abuse Medicaid manual, Chapter III, for coverage details and authorization requirements.

PRIVATE DUTY NURSING

Private duty nursing is covered for beneficiaries under age 21 who meet the medical criteria in this section for coverage. If the beneficiary is enrolled in or receiving case management services from one of the following programs, that program will authorize the private duty nursing services.

- Children's Special Health Care Services (CSHCS),
- Home and Community-Based Services Waiver for the Elderly and Disabled (known as the MI Choice Waiver),
- Children's Waiver (CMHSP), or
- Habilitation/Support Services Waiver (CMHSP).

For a Medicaid beneficiary who is not receiving services from one of the above programs, the CSHCS Program will review the request for authorization and authorize the services.

Note: The above programs cannot seek supplemental private duty nursing hours from another Medicaid Program (i.e., CSHCS, MI Choice Waiver, Children's Waiver, Habilitation Waiver).

PROVISION OF PRIVATE DUTY NURSING

Private duty nursing must be ordered by a physician and must be provided by a Medicaid enrolled registered nurse (RN), a Medicaid enrolled licensed practical nurse (LPN) who is working under the supervision of an RN, or a Medicaid enrolled private duty agency (refer to home health manual for private duty agency information). It is the responsibility of the LPN to secure the RN supervision.

Supervision of a Medicaid enrolled LPN must be by an RN who has at least one year of experience in any of the following areas: community health nursing, pediatric nursing, maternal and child health nursing, or a similar nursing practice. The Program requires an onsite supervisory visit by the supervising RN at least once every 2 months. The Medicaid enrolled LPN must maintain documentation that identifies the supervising RN.

If a beneficiary's services are performed exclusively by LPNs, the supervisory RN is responsible for completing the beneficiary's physical assessment and is required to participate in the development of the beneficiary's plan of care. **Note**: Assessments and supervisory visits are not covered separately.

Private duty nursing is not covered when rendered in a hospital, nursing facility (including nursing facility for mentally ill [NF/MI]), an intermediate care facility for mentally retarded (ICF/MR), or licensed adult foster care facility.

Private duty nursing is not covered when provided by an RN or LPN who is the beneficiary's spouse, legally responsible relative, step-parent, adoptive parent, legal guardian, or foster parent.

PRIOR AUTHORIZATION

Private duty nursing services must be authorized by one of the above-mentioned programs before services are provided.

Prior authorization of a particular private duty nursing provider to render services considers the following factors:

1) available third party resources;
2) beneficiary/family choice;
3) beneficiary's medical needs and age;

4) the knowledge and appropriate nursing skills needed for the specific case; and

5) the understanding of the concept and delivery of home care and linkages to relevant services and health care organizations in the area served.

If services are authorized, the provider will receive an approval letter. The provider must maintain the letter in the beneficiary's medical record. The prior authorization letter will contain a prior authorization number.

ASSESSMENT OF THIRD PARTY RESOURCES

The authorizing program assesses and documents the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, automobile insurance) for private duty nursing services and assists the beneficiary/family in selecting a private duty nursing provider in accordance with available third party coverage. This includes private health coverage held by, or on behalf of, a Michigan Department of Community Health beneficiary. This includes other insurance coverage for home care, as well as hospital and catastrophic care if relevant.

GENERAL ELIGIBILITY REQUIREMENTS

Private duty nursing is covered when all of the following requirements are met:

- The beneficiary is eligible for Medicaid in the home/community setting (i.e., in the non-institutional setting);
- The beneficiary meets the medical criteria for private duty nursing and is under the age of 21;
- Private duty nursing is appropriate, considering the beneficiary's health and medical care needs;
- Private duty nursing can be safely provided in the home setting; and
- The beneficiary, his/her family (or guardian), the beneficiary's physician, the Medicaid case manager, and RN (i.e., from the private duty nursing agency or the Medicaid enrolled RN, or the supervising RN for the Medicaid enrolled LPN) have collaborated and developed an integrated plan of care that identifies and addresses the beneficiary's need for private duty nursing. The private duty nursing must be under the direction of the beneficiary's physician; the physician must prescribe/order the services. The plan of care must be signed and dated by the beneficiary's physician, RN (as described above), and by the beneficiary or beneficiary's parent/guardian. The plan of care must be updated at least annually and must also be updated as needed based on the beneficiary's medical needs.

PLAN OF CARE

A written plan of care guides all services provided to the beneficiary by the private duty nursing provider. The care plan and the process for developing it reflect the beneficiary's and family's basic rights of self-determination and autonomy.

- Family members and the beneficiary (as appropriate to his/her maturity) participate in developing the plan of care. They are provided with accurate information and support appropriate to informed decision-making; and they must give informed consent for planned services.
- Beneficiary/family strengths, including cultural and ethnic identity, are respected and utilized in the delivery of care; services delivered in the home accommodate beneficiary/family life activities.
- The plan includes goals directed toward increasing beneficiary/family capability, effectiveness, and control.

- The plan includes compensatory services to support the growth and developmental potential of each beneficiary, given his/her disability or illness.
- Appointments are coordinated and services are scheduled with the goals of minimizing inconvenience to the beneficiary/family, and of facilitating the family's participation in the beneficiary's care.
- If the services are provided by LPNs, the plan of care must identify the frequency of the supervisory RN visits.

MEDICAL CRITERIA

Meeting the medical criteria for private duty nursing requires a finding that the beneficiary meets the criteria of *either* I and III below *or* II and III below.

I. The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
   - mechanical ventilation four or more hours per day or assisted respiration (Bi-PAP or CPAP); or
   - oral or tracheostomy suctioning 8 or more times in a 24-hour period; or
   - nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
   - total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
   - continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.

II. Frequent episodes of medical instability within the past 3 to 6 months, requiring skilled nursing assessments, judgments or interventions as described in III. below, due to a substantiated progressively debilitating physical disorder.

   - "frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past 6 months, or at least 6 episodes of medical instability related to the progressively debilitating physical disorder within the past 3 months;
   - "medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder;
   - "emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention in: placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
   - "progressively debilitating physical disorder" means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III. below) is required;
   - "substantiated" means documented in the clinical/medical record, including the nursing notes.

Note: For beneficiaries described in II. above, the requirement for frequent episodes of medical instability is applicable only to the initial determination of medical necessity for private duty nursing. Determination of continuing eligibility for private duty nursing for beneficiaries defined in II. above is based on the original need for skilled nursing assessments, judgments, or interventions as described in III below.

III. The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.
- Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

BENEFIT LIMITATIONS

The purpose of the private duty nursing benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. The benefit is not intended to supplant the care giving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary care giver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18 and the caregiver must provide a minimum of 8 hours of care during a typical 24-hour period.

Note: The time a beneficiary is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the 8 hours of obligated care as discussed above, nor can the 8 hours of care requirement for beneficiaries under age 18 be met by other public funded programs (e.g., Medicaid Home Help Program), or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).

Medicaid uses the following decision guide to establish the amount of private duty nursing that is approved. Except in emergency circumstances, Medicaid will not approve more than the maximum hours indicated on the guide.

DECISION GUIDE FOR ESTABLISHING MAXIMUM AMOUNT OF PRIVATE DUTY NURSING TO BE AUTHORIZED ON A DAILY BASIS

The Decision Guide that follows is a tool used to determine the appropriate range of nursing hours that can be authorized under the Medicaid private duty nursing benefit; it defines the 'benefit limitation' for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of private duty nursing (i.e., the number of hours) that can be authorized for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for private duty nursing, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). To illustrate, the number of hours covered by private health insurance will be subtracted from the hours approved under Medicaid private duty nursing. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized.

Only those factors which influence the maximum number of hours that can be authorized are included on this decision matrix. Other factors (e.g., additional dependent children, additional children with special needs, and required nighttime interventions) that impact the care giver's availability to provide care should be identified during an assessment of service needs. These factors have implications for service planning, and should be considered when determining the actual number of hours (within the range) to authorize.

The determination of the Intensity of Care category is a clinical judgment, and is based on the following factors: the beneficiary's medical condition, the type and frequency of needed nursing assessments, judgments and interventions, and the impact of delayed nursing interventions. Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary, but do not determine the number of hours of nursing for which the beneficiary is eligible. The '**High**' category includes beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least 1 time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. The '**Medium**' category includes beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least 1 time every 3 hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care. The '**Low**' category includes beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least 1 time every 3 hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

FAMILY SITUATION / RESOURCE CONSIDERATIONS	INTENSITY OF CARE Average Number of Hours Per Day		
	LOW	MEDIUM	HIGH
Factor I - Availability of Care Givers Living in the Home:			
a. 2 or more care givers; both work or are in school F/T or P/T	4-8	6-12	10-16
b. 2 or more care givers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
c. 2 or more care givers; neither works or is in school at least P/T	1-4	4-8	6-12
d. 1 care giver; works or is in school F/T or P/T	4-8	6-12	10-16
e. 1 care giver; does not work and is not a student	1-4	6-10	8-14
Factor II - Health Status of Care Giver(s):			
a. Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <=14
b. Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <=13
Factor III - School: This factor limits the maximum number of hours which can be authorized for a beneficiary: a) of any age in a center-based school program for more than 25 hours per week; or b) age six and older for whom there is no medical justification for a home-bound school program. In both cases, the lesser of the maximum 'allowable' for Factors I and II, or the maximum specified for Factor III applies.			
Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day.	Maximum of 8 hours per day.	Maximum of 12 hours per day.

DEFINITIONS

- 'Care giver': legally responsible person (e.g., birth parents, adoptive parents, spouses); paid foster parents; guardian or other adults who are not legally responsible or paid to provide care, but who choose to participate in providing care.

- 'Full-time (F/T)': working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.

- 'Part-time (P/T)': working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.

- 'Significant' health issues: one or more primary care giver(s) has a health or emotional condition that **prevents** the care giver from providing care to the beneficiary (e.g., beneficiary weighs 70 pounds and has no mobility and the primary care giver just had back surgery and is in a full-body cast).

- 'Some' health issues: one or more primary care giver(s) has a health or emotional condition, as documented by the care giver's treating physician, that **interferes** with, but does not prevent, provision of care (e.g., care giver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.).

The average number of hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in school, plus transportation time. **Note:** During "planned breaks" of at least 5 consecutive school days (e.g. spring break, summer vacation), additional hours can be authorized within the parameters of Factors I and II.

As a matter of Special Education law, the Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such 'health and related services' as necessary for the student to participate in his/her education program. Unless medically contraindicated, individuals of school age should attend school. Factor III applies when determining the maximum number of hours to be authorized for an individual of school age. The Medicaid Private Duty Nursing benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program).

EXCEPTION PROCESS

Because every beneficiary and his/her family is unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. Private duty nursing services which exceed the beneficiary's 'Benefit Limitation' as established by the *Decision Guide For Establishing Maximum Amount of Private Duty Nursing To Be Authorized on a Daily Basis* must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published private duty nursing benefit limitations may be granted subject to the provisions of this *Exception Process*. Exceptions are time-limited, as detailed below.

INITIATING AND DOCUMENTING A REQUEST FOR EXCEPTION

The request for an exception must be initiated by the beneficiary or his/her primary care giver. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional private duty nursing must be identified in the beneficiary's plan of care. As applicable, the plan of care must include strategies directed toward resolving the factors necessitating the exception.

Documentation must substantiate all of the following:

1. Current medical necessity for the exception;
2. Current lack of natural supports required for the provision of the needed level of support;
3. Additional private duty nursing services are essential to the successful implementation of the beneficiary's written plan of care; and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his/her condition.

EXCEPTION CRITERIA

Exceptions are time-limited and must reflect the increased identified needs of the beneficiary. Consideration for an exception shall be limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

1. A temporary alteration in the beneficiary's care needs following a hospitalization, resulting in one or both of the following:
    a. A temporary increase in the intensity of required assessments, judgments, and interventions.
    b. A temporary need for additional training to enable the primary care giver(s) to identify and meet the beneficiary's care needs.

The total number of additional private duty nursing hours cannot exceed 2 hours per day, for a maximum of 6 months.

2. The temporary inability of the primary care giver(s) to provide the required care, as the result of one of the following:
    a. An acute illness or injury of the primary care giver(s). The total number of additional private duty nursing hours cannot exceed 2 hours per day for the duration of the care giver's inability, not to exceed 6 months. In the event there is only 1 care giver living in the home and that care giver is hospitalized, a maximum of 24 hours per day can be authorized for each day the care giver is hospitalized.
    b. The death of the primary care giver(s) or an immediate family member. 'Immediate family member' is defined as the care giver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of 7 days.
    c. The home environment has been determined to be unstable, as evidenced by the Family Independence Agency protective or preventive services involvement.

The written plan of care and community-based care coordination activities must include strategies directed toward stabilizing service supports and/or the family situation. The maximum number of hours varies by the beneficiary's *Intensity of Care* category: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The length of time for this exception is 3 months or the time needed to stabilize service supports and/or family situation, whichever is less. A one time extension of up to 3 months may be made if there is documented progress toward achieving the stabilized home environment.

'Inability' is defined as the care giver is either unable to provide care, or is prevented from providing care.

SERVICE LOG

If private duty nursing is prior approved and care is initiated, a detailed log indicating the shift hours for each date of service for each procedure must be maintained. The provider must maintain this log in the beneficiary's medical record

Mileage: Staff mileage to the beneficiary's home is covered as a part of the private duty nursing service.

MULTIPLE BENEFICIARIES SEEN AT SAME LOCATION

The appropriate procedure codes and modifiers must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized.

OCCUPATIONAL THERAPY

Medically necessary occupational therapy services are covered by the Program which meet the requirements of this section. Evaluations must be ordered and therapy must be prescribed by a physician.

PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage of occupational therapy, a physician's prescription must include:

- name of the beneficiary
- therapy prescribed
- diagnosis(es) or medical condition(s)

If therapy is not initiated within 30 days after the prescription date, a new prescription is required.

COVERAGE CONDITIONS

Services are covered as occupational therapy when provided by

- an occupational therapist (OT) currently registered in Michigan
- a certified occupational therapy assistant (COTA) under the supervision of a currently-Michigan-registered OT (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OT and the OT must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). **NOTE:** All documentation must be reviewed and signed by the appropriately registered supervising OT.
- a student completing his/her clinical affiliation under the direct supervision of a currently-Michigan-registered OT. **NOTE:** All documentation must be reviewed and signed by the appropriately registered supervising OT.

For CSHCS beneficiaries, OT must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.

For beneficiaries 21 years of age and older, occupational therapy is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations, or participation restrictions.

For all beneficiaries, OT must be medically necessary, reasonable, and required to:

- return the beneficiary to the functional level prior to illness or disability
- return the beneficiary to a functional level that is appropriate to a stable medical status
- prevent a reduction in medical or functional status had the therapy not been provided

Therapy must require the skills, knowledge, and education of an OT. Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse, licensed physical therapist), family member, or caregiver are not be covered as occupational therapy.

Occupational therapy services may be covered for one or more of the following reasons:

- therapeutic use of occupations
- adaptation of environments and processes to enhance functional performance in occupations
- graded tasks (performance components) in activities as prerequisites to engagement in occupations
- design, fabrication, application, or training in the use of assisted technology or orthotic devices

- skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers.

Occupational evaluations and therapy are covered when provided by a Medicaid-enrolled home health agency in the home setting when:

- there is a need for adaptation of procedures, equipment, appliance, or prosthesis in the home setting identified by the OT.
- services will prevent undue exposure to infection and stress for the beneficiary, as identified by the physician or treating nurse.
- the OTR, physician, or treating nurse documents problems with access to an outpatient facility, or coordination or continuity of services.

NOTE:

- Therapy must be initiated within 30 days of the prescription date. A new prescription is required if therapy is not initiated within 30 days of the original prescription.
- OT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without prior approval.

Some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) will not be covered. It is the OT's responsibility to communicate with other therapists and coordinate services. Documentation should include a report of this coordination.

School-aged beneficiaries may be eligible to receive OT through multiple sources. Educational occupational therapy is provided by the school system and is not covered by the Program. Educational OT includes coordination for handwriting, increasing attention span, identifying colors and numbers.

EVALUATION

Evaluations are covered for the same medical diagnosis twice per year with a physician's order. If an evaluation is needed more frequently, prior approval is required.

The occupational therapy evaluation must be completed by an OT and must include:

- the treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis (e.g., medical diagnosis of cerebral palsy with contractures being treated)
- OT provided previously, including facility/site, dates, duration, and summary of change
- current therapy being provided to the beneficiary in this or other settings
- medical history as it relates to the current course of therapy
- the beneficiary's current functional status (functional baseline)
- the standardized and other evaluation tools used to establish the baseline and to document progress
- assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function
- assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension)

TREATMENT PLAN

The treatment plan consists of:

- time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals
- long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy
- anticipated frequency and duration of treatment required to meet short-term and long-term goals
- plan for discharge from service, including the development of follow-up activities/maintenance programs
- a statement detailing coordination of services with other therapies (e.g., medical and educational)
- signature of physician verifying acceptance of the treatment plan. **NOTE:** CSHCS beneficiaries must have a treatment plan signed by the referring physician.

INITIATION OF SERVICES

Therapy may be initiated upon completion of the assessment and development of a treatment plan that is reasonable and medically necessary as documented in the beneficiary's record. For the initial 60-day treatment period, up to 24 OT services may be provided in the home setting. For the outpatient hospital setting, up to 36 OT services may be provided in the initial 90-day treatment period.

REQUIREMENTS FOR CONTINUED ACTIVE THERAPY

To request prior approval to continue therapy beyond the initial 60 or 90 days, the OT must complete an MSA-115 (Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization). The OT may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting or up to 60 consecutive calendar days in the home setting.

Requests to continue active therapy must be accompanied by:

- a treatment summary of the previous period of OT, including measurable progress on each short-term and long-term goal. This should include the treating OT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan.
- a progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- a copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring physician and dated within 30 days prior to initiation of the continued service.
- a discharge plan.

Requests for prior approval may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670
OR
FAXED TO: (517) 335-0075

After processing, the MSA returns a copy of the prior approval. This copy should be retained in the beneficiary's medical record.

MAINTENANCE/MONITORING SERVICES

In some cases the beneficiary does not require active treatment, but the skills of an OT are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers or continued follow-up for the fit and function of orthotic or prosthetic devices. Prior approval is NOT required for these types of services for up to four times per 60-day period in the home or 90-day period in the outpatient hospital settings.

Requirements for Prior Approval of Continued Maintenance/Monitoring Services

Prior approval requests for continued maintenance/monitoring may ask approval for up to 90 consecutive calendar days in the outpatient setting and up to 60 consecutive calendar days in the home setting. The OT must complete an MSA-115, which must include:

- a service summary including a description of the skilled services being provided. This should include the treating OT's analysis of the rate of progress and justification for any change in the treatment plan. Documentation must relate to the period immediately prior to that time period for which prior approval is being requested.
- a comprehensive description or copy of the maintenance/activity plan.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- the anticipated frequency and duration of continued maintenance/monitoring.
- a discharge plan.

Requests for continued maintenance/monitoring may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670
OR
FAXED TO: (517) 335-0075

The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record.

DISCHARGE SUMMARY

When the beneficiary is discharged from therapy services, a discharge summary must be on file with the OT for identifying completion of services and status at discharge. The discharge summary includes:

- dates of service (i.e., initial and discharge dates)
- description of services provided

- functional status related to treatment areas/goals at discharge
- analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status
- description or copy of follow-up or maintenance program put into place, if appropriate
- identification of orthotic/prosthetic and adaptive equipment provided (e.g., hand splint) and its current utilization, if appropriate
- recommendations/referral to other services, if appropriate.

PHYSICAL THERAPY

Medically necessary physical therapy services are covered by the Program which meet the requirements of this section. Evaluations must be ordered and therapy must be prescribed by a physician.

PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage, a physician's prescription must include:

- name of the beneficiary
- therapy prescribed
- diagnosis(es) or medical condition(s)

If the therapy is not initiated within 30 days after the prescription date, a new prescription is required.

Physical therapy is covered in the following settings:

- physician's office (provided by or under the direct supervision of the physician)
- home (provided by a home health agency)
- outpatient hospital

COVERAGE CONDITIONS

Services are covered as physical therapy when provided by

- a Michigan-licensed physical therapist (LPT)
- a certified physicial therapy aide (CPTA) under the supervision of an LPT. The LPT supervises and monitors the CPTA's performance with continuous assessment of the beneficiary's progress. **NOTE:** All documentation must be reviewed and signed by the appropriately licensed supervising LPT.
- A physician or under the physician's direct supervision, when provided in the physician's office

For CSHCS beneficiaries, physical therapy must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.

For beneficiaries 21 years of age and older, physical therapy is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations, or participation restrictions.

For all beneficiaries, physical therapy must be medically necessary, reasonable, and necessary to:

- return the beneficiary to the functional level prior to illness or disability
- return the beneficiary to a functional level that is appropriate to a stable medical status within a reasonable amount of time.

Physical therapy requires the skills, knowledge, and education of an LPT. Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse, registered occupational therapist), family member, or caregiver are not covered as physical therapy.

Therapy services are covered for one or more of the following reasons:

- therapy can be expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills.
- the service is diagnostic.
- therapy is for a condition that is temporary in nature and creates decreased mobility.

- skilled services are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. **NOTE:** Routine provision of the maintenance/prevention program is not reimbursable as therapy.

Physical therapy evaluations and therapy are covered when provided by a Medicaid-enrolled home health agency in the home setting when:

- services will prevent undue exposure to infection and stress for the beneficiary, as identified by the physician or treating nurse.
- documented problems of access to an outpatient facility, coordination of services, or continuity of services as identified by an LPT, physician, or treating nurse.

NOTE:

- PT does not require concurrent skilled nursing care but must be provided through a Medicaid-enrolled home health agency.
- If therapy is not initiated within 30 days after the prescription date, a **new** prescription is required.
- PT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without prior approval.

Some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) will not be covered. It is the LPT's responsibility to communicate with other therapists and coordinate services. Documentation should include a report of this coordination.

School-aged beneficiaries may be eligible to receive PT through multiple sources. Educational physical therapy is provided by the school system and is not covered by the Program. Examples of educational PT include strengthening to play school sports, etc.

EVALUATION

Evaluations are covered for the same medical diagnosis twice per year with a physician's order. If an evaluation is needed more frequently, prior approval is required.

The physical therapy evaluation must be completed by an LPT. It must include:

- the treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with gait being treated)
- physical therapy provided previously, including facility/site, dates, duration, and summary of change
- current therapy being provided to the beneficiary in this or other settings
- medical history as it relates to the current course of therapy
- the beneficiary's current functional status (i.e., functional baseline)
- the standardized and other evaluation tools used to establish the baseline and to document progress
- assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function
- assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension)

TREATMENT PLAN

The physical therapy treatment plan consists of:

- time-related short-term goals that are measurable, functional, and significant to the beneficiary's function and/or mobility
- long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy
- anticipated frequency and duration of treatment required to meet short-term and long-term goals
- plan for discharge from service, including the development of follow-up activities/maintenance programs
- a statement detailing coordination of services with other therapies (e.g., medical and educational)
- signature of physician verifying acceptance of the treatment plan. **NOTE:** CSHCS beneficiaries must have a treatment plan signed by the referring physician.

INITIATION OF SERVICES

Therapy may be initiated upon completion of an evaluation and development of a treatment plan that is reasonable and medically necessary as documented in the beneficiary's medical record. PT may be provided up to a maximum of 24 times in the initial 60-day period in the home setting or up to 36 times in the initial 90-day period in the outpatient hospital setting or up to 20 times during a 75 day time period in the physician's office.

REQUIREMENTS FOR CONTINUED ACTIVE THERAPY

To request approval to continue therapy beyond the initial 60 or 90 days, the LPT must complete an MSA-115 (Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization). The LPT may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting or up to 60 consecutive calendar days in the home setting. NOTE: Prior authorization is not required for continuation of physical therapy provided in the physician's office.

Requests to continue active therapy must be accompanied by:

- a treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating LPT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan.
- a progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- a copy of the prescription hand-signed by the referring physician and dated within 30 days prior to initiation of continued service must be provided for each request.
- a discharge plan.

Requests for prior approval may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670
OR
FAXED TO: (517) 335-0075

After processing, the MSA returns a copy of the prior approval. This copy should be retained in the beneficiary's medical record.

MAINTENANCE/MONITORING SERVICES

In some cases, the beneficiary does not require active treatment, but the skills of an LPT are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers. Prior approval is NOT required for these types of services for up to four times per 60-day period in the home setting or 90 days in the outpatient hospital setting.

Requirements for Prior Approval of Continued Maintenance/Monitoring Services

Prior approval requests for continued maintenance/monitoring may ask approval for up to 90 consecutive calendar days in the outpatient setting and up to 60 consecutive calendar days in the home setting. The LPT must complete an MSA-115, which must include:

- a service summary including a description of the skilled services being provided. This should include the treating LPT's analysis of the rate of progress and justification for any change in the treatment plan. Documentation must relate to the period immediately prior to that time period for which prior approval is being requested.
- a comprehensive description or copy of the maintenance/activity plan.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- a discharge plan.

Requests for continued maintenance/monitoring may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670
OR
FAXED TO: (517) 335-0075

The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record.

DISCHARGE SUMMARY

When the beneficiary is discharged from PT, a discharge summary must be on file with the LPT for identifying the completion of services and the status at discharge. The discharge summary includes:

- dates of service (i.e., initial and discharge dates)
- description of services provided
- functional status related to treatment areas/goals at discharge

- analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status
- description or copy of follow-up or maintenance program put into place, if appropriate
- identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate
- recommendations/referral to other services, if appropriate

SPEECH AND LANGUAGE THERAPY

Medically necessary speech and language therapy services are covered by the Program which meet the requirements of this section. Evaluations must be ordered and therapy must be prescribed by a physician.

PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage, a prescription for therapy must include:

- name of the beneficiary
- therapy prescribed
- diagnosis(es) or medical condition(s)

If therapy Is not initiated within 30 days of the prescription date, a new prescription is required.

Speech therapy may be provided in the following settings:

- hearing and speech center
- home (only for Children's Special Health Care Services [CSHCS] beneficiaries) when provided by a home health agency in exceptional cases
- outpatient hospital

COVERAGE CONDITIONS

Services are covered as speech-language therapy when provided by:

- a speech-language pathologist (SLP) possessing a current Certificate of Clinical Competence (CCC) or Letter of Equivalency
- an appropriately supervised SLP candidate (i.e., in his/her clinical fellowship year [CFY] or having completed all requirements but has not obtained a CCC or Letter of Equivalency). **NOTE:** All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- a student completing his/her clinical affiliation under the direct supervision of an SLP having a current CCC or Letter of Equivalency. **NOTE:** All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

In exceptional cases, speech evaluations and therapy are covered in the home setting for CSHCS beneficiaries when:

- there is a need for adaptation of procedures or equipment in the home setting as identified by an SLP
- services will prevent undue exposure to infection and stress for a child at risk, as identified by the physician or treating nurse.
- documented problems of access to an outpatient hospital, coordination of services, or continuity of service is identified by an SLP, OTR, LPT, physician, or treating nurse.
- prior approval is obtained (this includes therapy for the initial 60 consecutive calendar days, continued active treatment, and maintenance/monitoring services).

NOTE:

- Speech-language evaluations and therapy services do not require concurrent skilled nursing care; however, **treatment always requires prior approval** and must be provided through a Medicaid-enrolled home health agency.
- Therapy may be requested for up to 60 consecutive calendar days in the home setting.

For CSHCS beneficiaries who are not enrolled in Medicaid; speech therapy must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary.

For Medicaid beneficiaries, who are not enrolled with CSHCS and who are under 21 years of age, therapy must be obtained from a Medicaid enrolled hearing and speech center.

For Medicaid beneficiaries 21 years of age and older, therapy may be provided by an outpatient hospital or a hearing and speech center.

Exception: Medicaid beneficiaries who are receiving specialty mental health services through a local CMHSP, therapy may be provided through the CMHSP.

For all beneficiaries, speech therapy must relate to a medical diagnosis. Coverage is limited to services for:

- articulation
- language
- rhythm
- swallowing
- training in the use of an augmentative communication device
- training in the use of an oral-pharyngeal prosthesis
- voice

Therapy must be reasonable, medically necessary, and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy would be when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech and the beneficiary would experience a reduction in medical or functional status were the therapy not provided.

Speech therapy services must require the skills, knowledge, and education of a certified speech-language pathologist to assess the beneficiary for deficits, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], registered occupational therapist [OTR]), family member, or caregiver are not covered as speech therapy.

Some areas of service (e.g., dysphagia, assistive technology) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) will not be covered. It is the treating therapist's responsibility to communicate with other practitioners and coordinate services. Documentation should include a report of this coordination.

Services to School-aged Beneficiaries

School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources. Educational speech is provided by the school system, and is not covered by Medicaid or CSHCS. Examples of educational speech include enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, identifying colors and numbers.

EVALUATION

Evaluations are covered for the same diagnosis twice per year with a physician's prescription. If an evaluation is needed more frequently, prior approval is required.

The speech-language evaluation must be completed by an SLP and must include:

- the disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphagia as the speech disorder being treated)

- speech therapy provided previously, including facility/site, dates, duration, and summary of measurable change
- current rehabilitation services being provided to the beneficiary in this or other settings
- medical history as it relates to the current course of therapy
- the beneficiary's current functional communication status (functional baseline)
- the standardized and other evaluation tools used to establish the baseline and to document progress
- assessment of the beneficiary's functional communication skill level, which must be measurable
- medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy

Evaluations may include, but are not limited to,

- Articulation – standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis.
- Language – standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es).
- Rhythm – standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication, and a medical diagnosis.
- Swallowing – copy of the videofluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment.
- Voice – copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis.

TREATMENT PLAN

The speech-language therapy treatment plan consists of:

- time-related short-term goals that are measurable, functional, and significant to the beneficiary's communication needs
- long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services
- anticipated frequency and duration of treatment required to meet short-term and long-term goals
- plan for discharge from service, including the development of follow-up activities/maintenance programs
- a statement detailing coordination of services with other therapies (e.g., medical and educational)
- signature of physician verifying acceptance of stated treatment plan. **NOTE:** CSHCS beneficiaries must have a treatment plan signed by the referring physician.

INITIATION OF SERVICES

Therapy may be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without prior approval. For this initial period, speech therapy may be provided up to a maximum of 36 times during the 90 consecutive calendar days in the hearing and speech center or outpatient hospital. Speech therapy may be provided up to a maximum of 24 times during the 60 consecutive calendar days in the home.

REQUIREMENTS FOR CONTINUED ACTIVE THERAPY FOR ALL SETTINGS

To request approval to continue therapy beyond the initial 60 or 90 days (as applicable), the SLP must complete a prior approval request (the applicable form depending upon the setting).

- MSA-1653-B (Special Services Prior Approval – Request/Authorization) must be used for the hearing and speech center setting.
- MSA-115 (Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization) must be used for the outpatient hospital setting and services requested through a home health agency for CSHCS.

The SLP may request up to 90 consecutive calendar days of continued active therapy in the hearing and speech center or outpatient hospital settings or up to 60 consecutive calendar days for the CSHCS beneficiary receiving therapy in the home setting.

Requests to continue active treatment must be accompanied by:

- a treatment summary of the previous period of service, including measurable progress on each short-term and long-term goal. This should include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. **NOTE:** Do not send daily treatment notes.
- a progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- the anticipated frequency and duration of maintenance/monitoring
- a discharge plan.
- a copy of the prescription hand-signed by the referring physician and dated within 30 days prior to initiation of continued service must be provided for each request.

Requests for prior approval may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670
OR
FAXED TO: (517) 335-0075

After processing, the MSA returns a copy of the prior approval. This copy should be retained in the beneficiary's medical record.

MAINTENANCE/MONITORING SERVICES

In some cases, the beneficiary does not require active treatment, but the skills of an SLP are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers. In the outpatient hospital or hearing and speech center, these types of service may be provided without prior approval for up to four times per 90-day period. For the home setting, these types of services require prior approval for a 60-day period.

Requirements for Approval of Continued Maintenance/Monitoring Services:

Continued maintenance/monitoring requires prior approval in all settings. The SLP must complete the prior approval request, which must include:

- a service summary including a description of the skilled services being provided. This should include the treating SLP's analysis of the rate of progress and justification for any change in treatment plan. Documentation must relate to the period immediately prior to that time period for which prior approval is being requested. It can cover up to three months.
- a comprehensive description or copy of the maintenance/ activity plan
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate
- the anticipated frequency and duration of continued maintenance/monitoring
- a discharge plan

Requests for continued maintenance/monitoring may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670
OR
FAXED TO: (517) 335-0075

The copy of the PA request returned to the provider should be retained in the beneficiary's medical record.

DISCHARGE SUMMARY

When the beneficiary is discharged from therapy services, it is requested that a discharge summary be on file with the SLP as a mechanism for identifying completion of services and status at discharge. The discharge summary should include:

- dates of service (i.e., initial and discharge dates)
- description of services provided
- functional status related to treatment areas/goals at discharge
- analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status
- description or copy of follow-up or maintenance program put into place, if appropriate
- identification of adaptive equipment provided and its current utilization, if appropriate
- recommendations/referral to other services, if appropriate

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

The Program covers anesthesia services provided by a Medicaid enrolled Certified Registered Nurse Anesthetist (CRNA). CRNA services are covered for the CRNA or for the entity with which the CRNA has an employment or contract relationship that provides for payment to be made to the entity. CRNAs must comply with Michigan scope of practice licensing laws and regulations.

If a rural hospital elects reasonable cost reimbursement for CRNA services under Medicare, the CRNA costs are included in the facility payments to the hospital and are not covered separately by the Program.

For specific coverage parameters, see anesthesia section of this chapter.

ENROLLMENT OF CRNA

A CRNA must be currently licensed in Michigan as a nurse and certified by the state as a CRNA. Provider enrollment forms are available from the Provider Enrollment Unit.

PHYSICIAN'S ASSISTANT

The Program covers services provided by a Physician's Assistant (PA) provided under the delegation and supervision of a physician licensed under part 170 or part 175 of Public Act 368 of 1978, as amended. The supervising physician must comply with the physician delegation and supervision requirements for utilizing PAs specified in Public Act 368 of 1978, as amended, and any related rules promulgated by the State of Michigan or its Departments.

The PA may provide direct patient care under the delegation and supervision of a physician at the medical care site where the physician regularly sees patients. Records must demonstrate that the PA provided the services and that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. When the supervising physician is not physically present on the premises, he/she must be continuously available to the PA through direct communication such as telephone, radio, or telecommunication. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to and does not replace the physician's personal services.

The Program covers the services of a PA as an assistant at surgery if all physician delegation and supervision requirements are met and the PA is an employee of the physician or physician group. If the PA is an employee of the hospital, the hospital receives reimbursement for the PA's professional services. The appropriate modifier must be reported to identify the PA as the assistant at surgery.

Services performed by a PA are only covered by the Program under the delegating/supervising physician's provider identification number. The supervising physician is responsible for the services performed by the PA.

PODIATRIST

The Program covers the medically necessary services of a podiatrist. Refer to the Podiatrist database on the DCH website for specific covered services.

Podiatrists should refer to the appropriate sections of this chapter for specific information related to the coverage of specific services.

CO-PAYMENT

A $2.00 copayment is required for each separately covered visit for beneficiaries age 21 and older who are not residents in a long term care facility or are not receiving services covered by Medicare. If more than one separately covered service is rendered on the same day, such as an office visit and laboratory services, only one co-payment is required. If a procedure such as a surgery with a global period is rendered, only one co-payment is required.

CONSULTATIONS

The Program covers limited and intermediate level consultations if requested by a physician.

PHYSICAL THERAPIST

The Program only covers Medicare coinsurance and deductible amounts for services provided by enrolled physical therapists. Physical therapy services must be ordered by a physician.

To qualify for coverage, services must be provided in the physical therapist's office. Services provided in the physician's office are covered under the physician and services provided in a long term care setting are covered under the long term care provider. Services must be provided by a licensed physical therapist or a physical therapy assistant under the direct supervision of the physical therapist.

CERTIFIED NURSE MIDWIFE

The Program covers services provided by enrolled certified nurse midwives (CNMs). Specific procedures covered for CNMs are listed in the Certified Nurse Midwife database available on the DCH website.

CNM coverage includes the management of low risk and uncomplicated pregnancies and services to essentially normal women and newborns. Medically complicated pregnancies and services to beneficiaries with high risk conditions MUST be referred to a physician. Services provided to high risk women and women with medical complications are only covered under the delegation and supervision of a physician.

ENROLLMENT

The CNM must enroll with Medicaid by submitting a provider enrollment agreement and a copy of their license. A CNM must be able to demonstrate a safe mechanism for physician consultation, collaboration, and referral within an alliance agreement which includes mutually approved protocols.

FAMILY PLANNING

The Program covers family planning services provided by CNMs. Refer to the family planning heading for specific coverage information. A CNM can only prescribe oral contraceptives under the delegation of a physician.

LABORATORY TESTS

Laboratory testing ordered by the CNM are covered and must be documented in the beneficiary's medical record by the ordering CNM regardless of where the tests are performed.

The following laboratory tests can be ordered by a CNM:

- Acetone and diacetic acid (ketone bodies), both qualitative and semi-quantitative
- Albumin, qualitative, semi-quantitative, and quantitative
- Antibody titer Rh system
- Blood typing, ABO, Rh(D), RBC antibody screening
- Blood count, RBC, WBC, hemoglobin, hematocrit, indices (MCV, MCH, MCHC)
- Culture, presumptive screening, for Neisseria, Gonorrhea, Candida, Hemophilus, or beta hemolytic Streptococci group A, etc.
- Culture, urine, definitive, with or without colony count
- Cytopathology, vaginal and/or cervical smears
- Glucose, qualitative, quantitative, timed specimen, tolerance
- Hemoglobin, electrophoretc separation, qualitative
- Hepatitis B test
- HIV detection
- Pregnancy test
- Quantitative sediment analysis and quantitative protein, 12 or 24 hour urine specimen
- Reticulocyte count, manual
- Routine prenatal laboratory services (OB profile)
- Rubella test, titer
- Syphilis test, (VDRL, RPR, etc.), qualitative

- Sickle cell slide test
- TB skin test, tine
- Susceptability (sensitivity) for aerobes
- Treponema antibodies, flourescent, absorbed
- Complete urinalysis
- Wet mount, smear, tissue, direct microscopic examination

The following laboratory tests are covered when performed by the CNM:

- Complete urinalysis
- Direct microscopic examination of a smear, wet mount, and/or tissue for fungi
- Hematocrit
- Hemoglobin
- Pregnancy testing

These tests are not covered for the CNM if rendered by an outside laboratory.

MATERNITY CARE

The Program covers antepartum care, delivery, and postpartum care provided by a CNM which comply with the requirements of this chapter.

Antepartum Care

Coverage for antepartum care includes all usual antepartum services provided prior to delivery and referral to Maternal Support Services (MSS) given the presence of psychosocial or nutritional factors that could adversely affect the pregnancy.

If the provider initiated prenatal care within the first six months of pregnancy through the month of delivery, the appropriate antepartum care CPT code is covered. If the beneficiary is seen by several CNMs within a group or multiple CNMs supervised by the same physician or physician group, the antepartum care package is covered. Refer to the maternity care and delivery services section of this chapter for details on coverage of antepartum care and when individual E/M services are covered.

Enhanced coverage is available for CNM prenatal care services to women under 17 years of age or to women 35 years of age or older with their first pregnancy if these women are NOT medically at risk. Refer to the Maternity care and Delivery section for specific coverage information. Enhanced coverage is also available for women with psychosocial or nutritional problems when confirmed by an enrolled Maternal Support Services (MSS) provider.

Delivery

Deliveries performed by a CNM are covered in a licensed setting only. Home deliveries and services associated with these deliveries are not covered. Coverage of the delivery includes monitoring, vaginal delivery, and resuscitation of the newborn infant when necessary.

Post-partum care

The Program covers post-partum office visits following the delivery. Routine post-partum hospital care for the mother is covered as a part of the delivery. Routine care of the newborn in the hospital is covered for the provider who examines and provides the total hospital care of the newborn regardless whether he/she performed the delivery. Refer to the services to newborns heading in this chapter for additional coverage information.

OFFICE VISITS

Visits not directly related to the antepartum care or follow up to a delivery, such as family planning visits, are covered under the appropriate office visit procedure code. Refer to the CNM database on the DCH website for a listing of office visit codes covered for CNMs. Refer to the Evaluation and Management Services section of this chapter for specific coverage information related to office visits.

PHARMACY

Pharmaceuticals can only be ordered by a CNM under the delegation of a physician. The pharmaceutical must be provided by an enrolled pharmacy, or if appropriate, by an enrolled family planning clinic.

NURSE PRACTITIONERS

The Program covers the services of a nurse practitioner (NP) when provided pursuant to a current collaborative practice agreement with a physician. The Program covers NP services only if the services would be covered if furnished by a physician, the services are not otherwise excluded from coverage, and the NP is legally authorized to perform the services under state law.

The services are subject to the limitations that apply to physician services. Certain services such as long-term-care facility visits, consultations, initial hospital care, may be restricted to physicians by program policy or federal and state statutes and are not covered for NPs. Professional services are only covered when the services have been personally performed by the NP.

Determination of the medical necessity and appropriateness of services is the responsibility of the NP/physician based on the terms of the agreement.

Services provided by NPs while a hospital employee are included in the hospital's charges and are not covered separately for the individual NP. Services which are covered for other enrolled providers such as a home health agency, a long term care facility, a family planning clinic, etc., are not separately covered for the NP. Services provided jointly by a NP and the supervising physician are covered for only one practitioner. Some services are only covered by the Program under the physician's ID number. Refer to the appropriate section of this chapter for more information.

NOTE: NPs are not required to enroll in the Program. They may provide services to Medicaid beneficiaries under the employing physician's ID number.

Once enrolled, the NP may submit bills to the program directly if the beneficiary is in fee-for-service Medicaid. For beneficiaries enrolled in a Medicaid Health Plan (MHP), the NP must negotiate provider terms and payment arrangements with each individual MHP.

ENROLLMENT OF NURSE PRACTITIONERS

In order for the NP to enroll, he/she must comply with all of the following:

- meet state qualifications for nurse practitioners,
- have an ambulatory based practice,
- provide services according to the terms of a written collaborative practice agreement in place with a physician,
- complete the appropriate enrollment forms and a Nurse Practitioner/Physician Agreement (MSA-1575),
- attest to the type of nurse practice engaged in, such as pediatric, family, geriatric, adult, etc.
- if engaged in family or pediatric nurse practice, continue to provide proof of certification as a family nurse practitioner or a pediatric nurse practitioner by the appropriate accepted national credentialing body. (See Michigan Rule 338.10404 (3).)

COLLABORATIVE PRACTICE AGREEMENT

This is a formal document under which the NP and the physician deliver covered medical services. This agreement must be available to the Program upon request. Services must be delivered within each practitioner's scope of practice as allowed by federal regulations and state law. Services provided by the NP under the physician's delegation and supervision are also included.

The collaborative practice agreement must be reviewed at least annually and updated as necessary. The Program must be notified by the NP if the agreement is dissolved so the NP's enrollment with the Program can be terminated. The Program only covers NP services provided within the provisions of the agreement.